MEDICARE BENEFICIARIES WHO INVOLUNTARILY DISENROLL FROM THEIR HEALTH PLANS

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Final Report

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EXECUTIVE SUMMARY

While the number of plans announcing their intention to withdraw or cut back their participation in the Medicare+Choice (M+C) program in 2003 was lower than in the previous 2 years, the cumulative result is that in 5 years, over 2.4 million Medicare beneficiaries have become "involuntary" disenrollees, forced to change their health insurance coverage due to the decisions of others. A number of recent studies have looked at reasons behind plans' decisions to leave M+C, compiling a list of plan factors, health care market factors, and M+C program characteristics that contribute to these decisions (Achman and Gold, 2002; Lake and Brown, 2002; Stuber et al., 2001; Draper et al., 2002; Dallek and Dennington, 2002). Of particular concern to the Centers for Medicare & Medicaid Services (CMS), however, is the effect of the withdrawals at the individual beneficiary level. Consequently, CMS decided to conduct a survey to assess the ongoing impact of Medicare managed care market withdrawal on beneficiaries. Of particular interest were beneficiaries' understanding of their coverage options when their plans withdrew and the impact on their coverage and care. The survey was first conducted in 2001 and then again in 2002. This report summarizes results from the 2002 Survey of Medicare Beneficiaries Who Involuntarily Disenroll From Their Health Plans, conducted for CMS by the Center for Health Systems Research & Analysis at the University of Wisconsin at Madison and RTI International1 in the winter and spring of 2002.

The purpose of this survey was to collect data that will help CMS understand how Medicare beneficiaries are affected by Medicare health plan withdrawals and reductions in service areas. Understanding the difficulties some beneficiaries may have in response to changes in the health care system will help CMS meet its goal of providing all Medicare beneficiaries with adequate health care.

The survey included a sample of Medicare beneficiaries who were enrolled in managed care plans that either terminated their risk contracts or reduced their service areas as of January 1, 2002. The survey was conducted as a mail survey with telephone follow-up of non-respondents. The sample included a total of 5,074 Medicare beneficiaries whose managed care health plan stopped serving them at the end of 2001. Data were collected between February and May of 2002, achieving an overall response rate of 83.7 percent.

The survey sample was stratified into four groups of beneficiaries: those who qualified for Medicare as a result of their age and who lived in areas where another Medicare managed care plan was available after December 31, 2001; those who qualified for Medicare as a result of their age and who lived in areas where there were no Medicare managed care plans available; those who qualified for Medicare as a result of disability and who lived in areas where another Medicare managed care plan was available after December 31, 2001; and those who qualified for Medicare as a result of disability and who lived in areas where there were no Medicare managed care plans available. (About one of every five beneficiaries affected by the plan withdrawals lived in areas where no other Medicare managed care plan was available.)

Of the 5,091 Medicare beneficiaries in the sample, 2,582 beneficiaries resided in areas where another Medicare managed care plan was available after December 31, 2001, and 2,509 beneficiaries lived in areas where there were no Medicare managed care plans available. A total of 3,987 beneficiaries completed the questionnaire by mail or by phone: of these 1,941 resided in areas where

[1] RTI International is a trade name of Research Triangle Institute.

another Medicare managed care plan was available and 2,046 beneficiaries lived in areas where no Medicare managed care plans were available.

Key findings from the analyses of the survey responses include the following:

Information about plan withdrawal

- Sixty-five percent of beneficiaries affected by plan withdrawals in 2002 first found that their plan would no longer cover them from the plan itself.
- Ninety-four percent recalled receiving a letter from their plan about their withdrawal.

Awareness of options

- Only 4 out of 10 involuntary disenrollees living in areas without any other Medicare health maintenance organizations (HMOs) knew that there was no other Medicare HMO available to them.
- Seventy percent of beneficiaries thought that there was supplemental insurance available to them, although disabled beneficiaries (those under 65 years of age) were significantly less likely to think this than aged beneficiaries (those 65 years of age and over). Less educated and non-white beneficiaries and those in poor health were less likely to know if supplemental insurance was available.
- Fewer of the beneficiaries affected by the plan withdrawals in 2002 than those affected in 2001 understood what would happen if they did not change their insurance when their plan stopped covering them. While 43 percent of the involuntary disenrollees in 2002 (down from 48 percent in 2001) thought that they would be covered by Original Medicare, almost one-third thought that they would end up with no health insurance (33 percent in 2002 compared to 28 percent in 2001).
- Non-white beneficiaries, those with less than a ninth-grade education, and those who first found out about their plan's withdrawal from the media were less likely to understand what would happen to them.

Concerns about plan withdrawals

- About 7 in 10 beneficiaries were very or somewhat concerned about getting or paying for care after their plan stopped covering them. This level of concern about plan withdrawals in 2002 was similar to the level of concern in 2001.
- Beneficiaries who are disabled, have less than ninth-grade education, or who are in poor health were more likely to be very concerned about getting and paying for care when they heard that their plan would stop covering them.

Evaluation of information and time to choose

- Thirty-five percent of beneficiaries affected by the plan withdrawals in 2002 felt that they did not receive enough information about their coverage options when their plan stopped covering them. This percentage was unchanged from the previous year.
- Beneficiaries were somewhat less satisfied with the amount of time they had to choose new coverage in anticipation of the 2002 withdrawals compared to 2001 (37 percent were not very or not at all satisfied in 2002 versus 32 percent in 2001).

New coverage arrangements

- Among beneficiaries (both aged and disabled) living in an area with another Medicare HMO, following the withdrawal of their former plan, 40 percent of beneficiaries enrolled in another Medicare HMO and 30 percent had supplemental insurance other than that provided by an employer. Sixteen percent had supplemental coverage through a former employer, Medicaid, or a private fee-for-service (PFFS) plan. Fourteen percent ended up with only Original Medicare.
- Among aged and disabled beneficiaries living in areas without another Medicare HMO, 53 percent had supplemental insurance other than that provided by an employer and 22 percent ended up with only Original Medicare.
- Overall, less than 1 percent of involuntary disenrollees enrolled in a Medicare private fee-for-service (PFFS) plan, but, among disabled beneficiaries in areas without a choice of another Medicare HMO, 8 percent enrolled in a PFFS plan. Disabled beneficiaries were more likely to enroll in a Medicare HMO, if available, and were less likely to have supplemental insurance.

Financial implications

- Fifty-five percent of involuntary disenrollees in 2002 (and 2001) ended up paying more for monthly premiums after their plan withdrew. Compared to beneficiaries who joined another Medicare HMO, beneficiaries who joined a PFFS plan or had supplemental insurance were more likely to report higher premiums.
- Sixty-three percent of involuntary disenrollees in 2002 reported that their former plan covered the cost of prescription medicines, down from 74 percent in 2001. Forty-seven percent reported that their new coverage paid for medicines in 2002 compared to 53 percent in 2001.

Implications for care

- Sixteen percent of involuntary disenrollees in 2002 reported that they had to change their personal doctor or nurse when their former plan stopped covering them, down from 21 percent in 2001.
- Of those beneficiaries who were seeing a specialist when their plan withdrew, 14 percent had to stop seeing that specialist under their new coverage, down from 22 percent in 2001.
- Eight percent of beneficiaries reported having trouble getting care in 2002, and 18 percent reported delaying getting care due to cost, compared to 11 percent and 22 percent in 2001. However, disabled beneficiaries, those with less education, and those in poor health were more likely than other beneficiaries to delay care and were more likely not to get medicines that had been prescribed for them.

Satisfaction with new coverage

- Fewer beneficiaries (30 percent) reported being less satisfied with their new coverage in 2002 than in 2001 (37 percent). Again, disabled beneficiaries and those in poor to fair health were far more likely to evidence dissatisfaction than other beneficiaries.

Overall, the incidence of potentially negative impacts of plan withdrawals, such as disruptions in provider arrangements and reduced access to care, appear to have affected fewer

beneficiaries in 2002 than in 2001. However, those in vulnerable subgroups, such as the disabled, those in poor health, and those with less education, continued to be more likely to experience negative consequences than other beneficiaries. Furthermore, there was no observed improvement in the level of awareness of options or understanding of what would happen when a plan stopped covering its beneficiaries.

INTRODUCTION

Between 1999 and 2001, nearly half the health plans in Medicare+Choice (M+C) either completely or partially withdrew from the program, and virtually no new plans entered the M+C program (Lake and Brown, 2002). In addition, among plans that now remain in M+C, premiums are increasing while benefits are decreasing (Achman and Gold, 2002). Together, eight national managed care firms[2] enroll 7 of every 10 M+C enrollees nationally. From 1998 to 2001 the number of M+C contracts held by these firms dropped 61 percent, 5 of the 8 firms experienced significant declines in their M+C enrollment, and all of the firms underwent significant geographic retrenchment (i.e., fewer counties served) (Draper et al., 2002). Most recently, 9 health plans announced their decision to leave the Medicare program, and 23 health plans and 1 PFFS plan will reduce their service areas in 2003 (CMS, September 2002).

Factors associated with plans' decisions to withdraw completely from M+C or reduce their service areas can be divided into three groups: plan characteristics, health care market factors (primarily, but not all, local), and factors inherent to the M+C program.

Plan characteristics include lower enrollments (Achman and Gold, 2002; Lake and Brown, 2002); higher premiums (Achman and Gold, 2002); less generous and less stable benefit packages (Achman and Gold, 2002); plan ownership and profit status (Lake and Brown, 2002),[3] low market share (Stuber et al., 2001); decisions made by plans' national headquarters instead of local offices (Stuber et al., 2001); implications for other lines of business and/or products (i.e. enrollment could be going to other more profitable Medicare products)(Draper et al., 2002); and, for private firms, pressures from Wall Street (Draper et al., 2002).

A number of health care market factors that may contribute to plans' withdrawal decisions include rural location[4] (Achman and Gold, 2002; Lake and Brown, 2002); lower M+C penetration rates (Lake and Brown, 2002); large numbers of competing plans (Lake and Brown, 2002); increasing costs of hospital care and other medical services (Lake and Brown, 2002; Draper et al., 2002); increases in utilization and costs of medical care, such as prescription drugs (Stuber et al., 2001); health care providers' unwillingness to accept capitated payment rates or contract with M+C plans (particularly a problem in rural areas); provider network instability/MD withdrawals (Stuber et al., 2001; Draper et al., 2002; Dallek and Dennington, 2002); contentious plan-provider relations due to payment rates considered insufficient, claims denials, and payment delays (Dallek and Dennington, 2002); provider group financial problems (Dallek and Dennington, 2002); fears of adverse selection (Stuber et al., 2001); and general consumer and provider backlash against managed care (Draper et al., 2002).

Finally, a number of characteristics of the M+C program itself, such as the payment levels to plans, early notification dates, and regulatory burden, likely contribute to firms' decisions to withdraw or cut back their participation (Lake and Brown, 2002; Stuber et al., 2001; Draper et al., 2002).

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[2] Aetna, Blue Cross/Blue Shield (43 independent and locally operated BC/CS plans), CIGNA, Health Net, Humana, Kaiser Permanente, PacifiCare, and United HealthCare.

[3] For-profit plans are more likely to withdraw than non-profit plans (Lake and Brown, 2002). Nationally owned plans are more likely to withdraw than locally owned plans (Lake and Brown, 2002; Draper et al., 2002).

[4] Rural locations imply lower payment rates, difficulty with provider networks, and lower concentration of beneficiaries.

The net result of plans' decisions to withdraw is that approximately 2.4 million Medicare beneficiaries have already been or will be affected between 1998 and 2003:

- Medicare health care plan withdrawals resulted in 407,000 beneficiaries (about 6.5 percent of 1998 M+C enrollees) making a plan change in January 1999.
- In 2000, 327,000 beneficiaries (5 percent of M+C enrollees) were affected by plans' withdrawals or reduction in service areas.
- In 2001, 934,000 Medicare beneficiaries (15 percent of total enrollment in M+C) were forced to make new choices about their health plan coverage when their Medicare health care plan withdrew from the program or reduced their service areas.
- In 2002, 536,000 (10 percent of M+C enrollees) were affected.
- The 2003 withdrawals will affect approximately 217,000 beneficiaries.

The effect of withdrawals by Medicare managed care plans at the individual beneficiary level can be particularly disruptive, as some beneficiaries have to change providers and break the chain of continuity in their care. Prior to the 2001 Survey of Medicare Beneficiaries Who Involuntary Disenroll from Their Health Plans (referred to as the Survey of Involuntary Disenrollees) sponsored by the Centers for Medicare & Medicaid Services (CMS) (Booske et al., 2002), few studies had documented the experiences these involuntary disenrollees have in accessing information about their M+C options and the impact of their new coverage (Kaiser Family Foundation, 1999; General Accounting Office, 1999; Gold and Justh, 2000--reporting on the Monitoring Medicare+Choice Project of Mathematica Policy Research, Inc., funded by Robert Wood Johnson Foundation). Consequently, CMS decided to conduct a second round of the Survey of Involuntary Disenrollees in 2002 to assess the ongoing impact of Medicare managed care market withdrawal on beneficiaries.

Most HMOs that participate in Medicare offer additional benefits outside the regular Medicare benefit package. Extra benefits may include prescription drugs, unlimited hospitalization, preventive services, and co-payments that, while no longer as low as during the early years of Medicare+Choice, may still be less costly than coverage under other Medicare options (Gold and Achman, 2002). Many beneficiaries have come to rely on the extra benefits they receive from their HMO, particularly prescription drug coverage. Replacing these benefits through Medigap insurance is usually very expensive, and may be unaffordable for some. Joining another HMO or going to fee-for-service (FFS) may also force many beneficiaries to change doctors, creating dissatisfaction and disrupting existing patterns of care. There has therefore been concern among policy-makers about the impact of the continuing HMO withdrawals on the beneficiary population.

The purpose of the 2002 Survey of Medicare Beneficiaries Who Involuntarily Disenroll from Their Health Plans was to investigate the impact of plans' withdrawals on Medicare beneficiaries. CMS requires that withdrawing plans notify their enrollees of their intent to withdraw from Medicare+Choice and inform them of their coverage options. More information about CMS' strategies for the 2002 plan withdrawals is available in a CMS fact sheet available on the CMS website[5] (CMS, September 2001).

[5] The fact sheet is titled "Protecting Medicare Beneficiaries when their Medicare+Choice Organization Withdraws" and is dated September 1, 2001. It is available at http://cms.hhs.gov/media/press/release.asp?Counter=402.

This survey was designed to collect data that will help CMS understand how Medicare beneficiaries are affected by Medicare health plan withdrawals and reductions in service area. Understanding the difficulties some beneficiaries may have in response to changes in the health care system will help CMS meet its goal of providing all Medicare beneficiaries with adequate health care.

The survey was conducted in the winter and spring of 2002 as a mail survey with telephone follow-up of mail survey non-respondents. The survey included a sample of 5,091 Medicare beneficiaries who were enrolled in managed care plans that either terminated their risk contracts or reduced their service areas as of January 1, 2001. Of these, 2,582 beneficiaries resided in areas where another Medicare managed care plan was available after December 31, 2001, and 2,509 beneficiaries lived in areas where there were no Medicare managed care plans available. Disabled patients may be adversely impacted by plan withdrawals because they tend to have high health care expenses, therefore the survey sample included 1,073 disabled beneficiaries, 539 of whom were in areas where another Medicare managed care plan was available after December 31, 2001, and 534 of whom were in areas where there were no Medicare managed care plans available.

This report describes the methods and the results of that survey, which was conducted for the Centers for Medicare & Medicaid Services by the Center for Health Systems Research & Analysis (CHSRA) at the University of Wisconsin at Madison and RTI International. The appendices to this report contain additional details about data collection activities and non-response analysis (***Appendices A*** and ***B***), tables of results (***Appendix C***), and a copy of the survey questionnaire (***Appendix D***).

METHODOLOGY

THE SURVEY INSTRUMENT

The questionnaire used in the 2002 Survey of Medicare Beneficiaries Who Involuntarily Disenroll from Their Health Plans consisted of 36 questions about:

- The sample member's former health insurance;
- Choosing new health insurance;
- The sample member's current health insurance;
- Getting needed care since the sample member left his/her former plan; and
- The sample member's health status and demographic characteristics.

THE SURVEY SAMPLE AND DATA COLLECTION RESULTS

For the aged population, a sampling frame was constructed that included all enrollees, as of October 1, 2001, in plans that terminated or reduced their service areas effective January 1, 2002. The reason for using a 3-month window was to capture people who stayed in the plan until the end of the year, as well as those who may have left earlier, in the event that there were differences between these types of enrollees. All beneficiaries who lived outside the United States, as well as deceased and institutionalized sample members, were excluded from the sampling frame. Once the frame for the aged population was constructed, beneficiaries were assigned to one of two strata – those who lived in areas where another Medicare managed care plan was available after December 31, 2001, and those who lived in areas in which no other Medicare plan was available. A separate sample consisting of disabled Medicare beneficiaries who were affected by plans' withdrawals and reduction in service areas was selected within each of these two areas as well.

The sample sizes for the "choice" and "no choice" strata were based on a goal of obtaining 3,000 completed interviews from the aged Medicare beneficiaries and 385 completed interviews from disabled Medicare beneficiaries. The number of beneficiaries selected in each stratum is shown in ***Table 1***.

As indicated, the Survey of Involuntary Disenrollees was conducted as a mail survey with telephone follow-up with mail survey non-respondents. Data collection activities, which are described in ***Appendix A***, resulted in an overall response rate of 83.7 percent. This response rate was calculated using the following formula:

> **Numerator** - the number of completed interviews.
> **Denominator** - All sample members in the sample ***minus*** those who were institutionalized or deceased, and those who reported that they were still enrolled in the sample plan or left the plan because they moved out of the plan's service area.

Table 1
2002 Survey of Involuntary Disenrollees sample size by stratum

Stratum number	Stratum title	Sample size
1	"Choice, Aged" included non-disabled Medicare beneficiaries who lived in areas in which another Medicare health plan was available after December 31, 2001.	2,043
2	"No Choice, Aged" included non-disabled Medicare beneficiaries who lived in areas in which no other Medicare health plan was available after December 31, 2001.	1,975
3	"Choice, Disabled" included disabled Medicare beneficiaries who lived in areas in which another Medicare health plan was available after December 31, 2001.	539
4	"No Choice, Disabled" included disabled Medicare beneficiaries who lived in areas in which another Medicare health plan was available after December 31, 2001.	534
Total		**5,091**

The response rates by stratum and overall are shown in ***Table 2*** below.

Table 2
2002 Survey of Involuntary Disenrollees response rates by stratum and overall

Stratum number	Stratum title	Response rate, percent
1	"Choice, Aged"	82.9
2	"No Choice, Aged"	86.3
3	"Choice, Disabled"	76.4
4	"No Choice, Disabled"	84.4
Overall		**83.7**

The results presented in this report are based on weighted data. A weighting model was developed using an iterative process. On the first iteration, the weights were the same as the design weights. The initial sampling frame included 393,930 aged Medicare beneficiaries who resided in a county where another Medicare HMO was available; 73,636 aged beneficiaries in counties without another Medicare HMO; 25,884 disabled beneficiaries living in a county where there was another HMO available; and 7,162 disabled beneficiaries living in a county without another Medicare HMO. All beneficiaries were enrolled on October 1, 2001, in plans that withdrew from the Medicare program or reduced their service areas effective January 1, 2002.

Sample members were classified as respondents or non-respondents and modeled using logistic regression. Respondents included sample members with a completed survey as well as sample members where status information was provided (i.e., beneficiaries who were identified as deceased) were included in this process. True non-respondents (i.e., those who were not reached or who refused to participate) were assigned a weight of zero. Predictor variables initially included demographics, geographic indicators, length of enrollment, and dual eligibility. Of these variables,

age, race, and addresses with rural routes were statistically significant. The odds of a response steadily decreased with the sample members who were 65 years of age or older. In particular, those who were 85 years of age or older were statistically less likely to complete a survey. Minority populations (Asian, Hispanic, Native American, others) were more likely to complete the survey compared to whites (recruitment materials and the survey were available in Spanish). There was no difference between blacks and whites. Finally, beneficiaries with addresses that contained a rural route were much less likely to respond.

At the end of that iterative process, the weights summed up to the population of interest in each stratum because the design variable was always retained with the modeling. However, because some respondents may be deemed "ineligible," the final weights summed back to the *estimated total of the eligible population* and were close, but not identical, to the distribution in the initial sampling frame. The totals of the weights will thus always be less than the totals on the original sampling frame (unless everyone sampled is considered eligible). Additional information about weighting and the non-response analysis conducted on the survey sample is provided in ***Appendix B***.

Other variables were retained in the final model that had p-values between 0.05 and 0.20. Although they were not statistically significant, they did improve the overall fit of the model. They included gender, dual eligibility, census region, addresses with P.O. boxes, and addresses that possibly indicated a gatekeeper (e.g., John Doe in care of Jane Doe). This final non-response model was then used to iteratively update the initial sampling weights to account for response propensities.

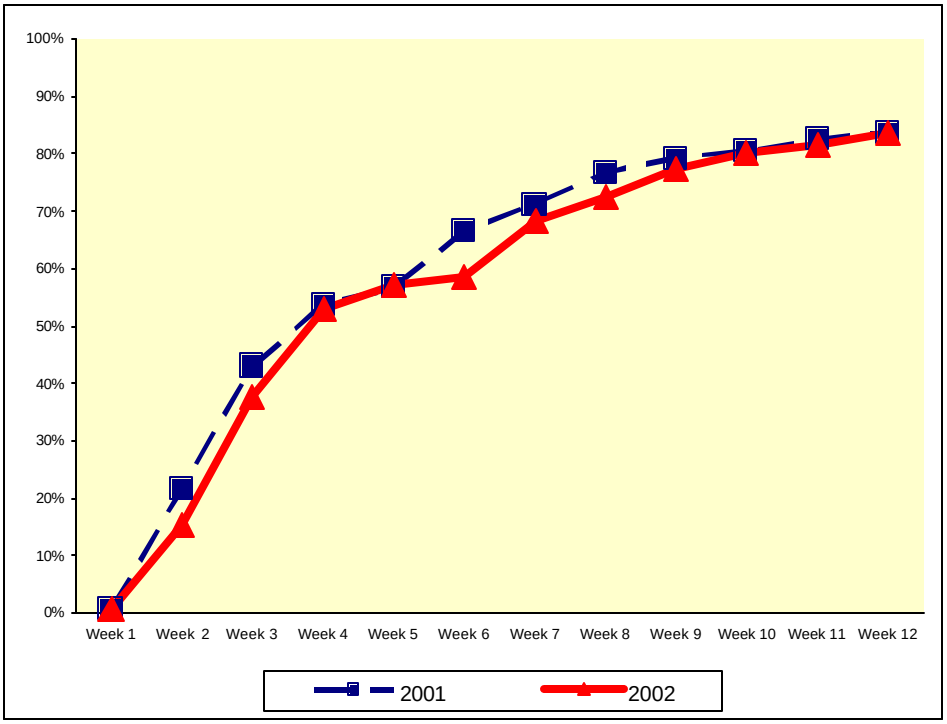
COMPARISON OF 2001 AND 2002 SURVEYS

Figure 1 below provides a comparison of the 2001 and 2002 survey response rates during each week of the data collection period. The response rate was identical in each of these survey years: 83.7 percent. In both the 2001 and 2002 surveys the response rate from the mail survey alone (before telephone follow-up began) was between 68 and 70 percent. Factors that may have contributed to the high response rate on these surveys include the saliency of the topic to the sample member, the brevity of the questionnaire (and telephone interview), and ease of understanding information included in the survey cover letters and in the frequently asked questions and answers brochure.

DATA ANALYSIS

Descriptive statistics and chi-square tests of independence were used to assess statistical associations between a number of potential outcomes of the plan withdrawals and beneficiary characteristics. These outcomes include new coverage arrangements and the financial, psychological, and care-related impacts of the plan withdrawals from the Medicare program. The complete set of descriptive statistics and statistical tests are provided in ***Appendix C***. Analyses were conducted using SUDAAN® that appropriately accounts for the sample weighting approach in calculating standard errors. Findings of significance at the 99-percent probability level and differences of at least 10 percentage reports are highlighted in the text. In addition, where appropriate, results of multivariate analysis (using logistic regression since the dependent variables were all dichotomous outcomes) are reported to further examine the relationships between beneficiary characteristics and the impact of plan withdrawals. Additional variables used in the logistic regression analyses, such as the Medicare managed care penetration rates and the payment

Figure 1
Comparison of response rates by survey year



rates that M+C organizations (MCOs) receive per enrollee per month, were derived from CMS files available to the public at www.cms.gov[6] (CMS, December 2001). Some tables include data based on CMS region. These regions are referred to by number and regional office location in tables and text. The states included in each of these regions are listed below:

Region I - Boston: CT, ME, MA, NH, RI, VT

Region II - New York: NY, NJ, PR, VI

Region III - Philadelphia: DC, DE, MD, PA, VA, WV

Region IV - Atlanta: AL, FL, GA, KY, MS, NC, SC, TN

Region V - Chicago: IL, MI, IN, MN, OH, WI

Region VI - Dallas: AR, LA, TX, NM, OK

Region VII - Kansas City: KS, MO, IA, NE

Region VIII - Denver: CO, MT, ND, SD, UT, WY

Region IX - San Francisco: AZ, CA, HI, NV

Region X - Seattle: WA, OR, ID, AK

[6] Overall M+C payment rates for 2001 (i.e., the sum of Medicare Part A and Part B) and county-level Medicare market penetration rates for December 2001 are available in the quarterly state/county data files titled Medicare Managed Care Market Penetration for All Medicare Plan Contractors at http://www.cms.gov/healthplans/statistics/mpscpt/.

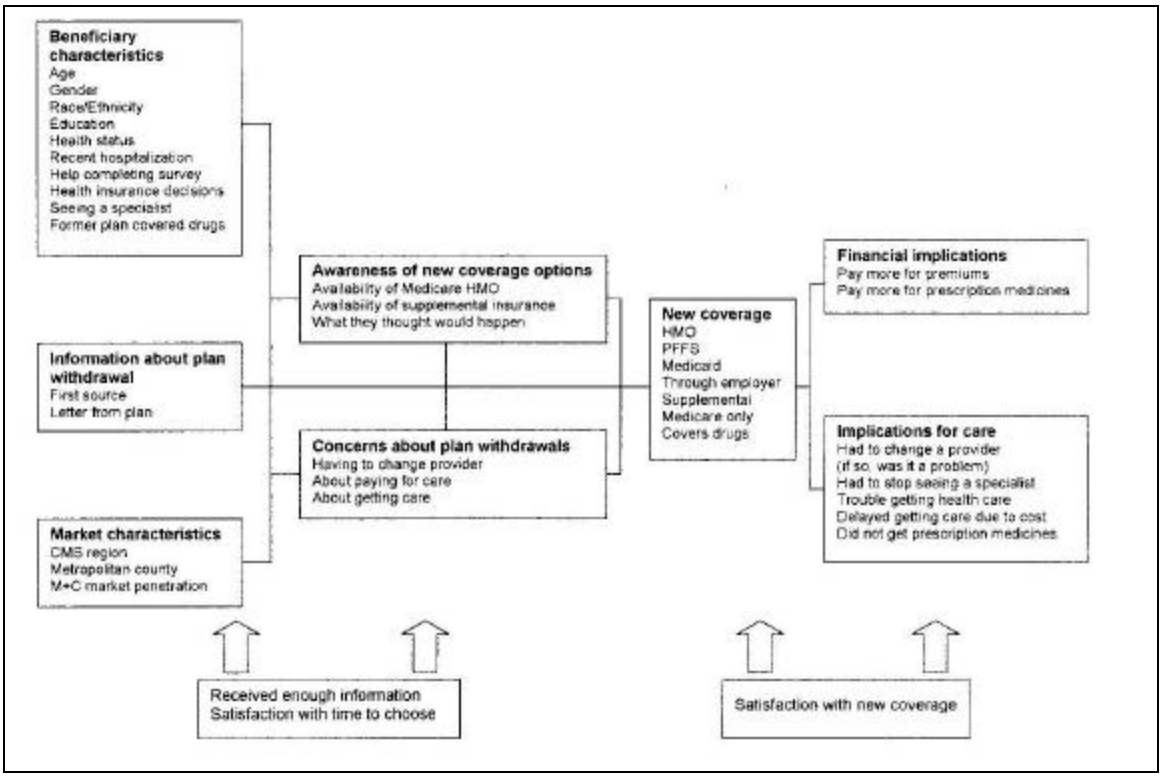
Regions VII, VIII, and X were combined for analysis due to smaller number of involuntary disenrollees in these states.

RESULTS

OVERVIEW

Figure 2 provides a summary of the conceptual framework used for investigating the impact of the 2002 plan withdrawals on Medicare beneficiaries. On the left of the framework are the starting points: the characteristics of the involuntary disenrollees (i.e., the beneficiaries affected by plans' decisions to withdraw completely from the M+C program or to reduce their service areas); the information the involuntary disenrollees received about the plan withdrawals; and some characteristics of the M+C market. The center of the framework captures beneficiaries' awareness of the new coverage options available to them, the concerns that they had upon hearing about their plan's withdrawal, and their new coverage arrangements after the plan withdrawals. The right side of the framework presents the financial implications of this new coverage and the implications for care (i.e., the impact on provider arrangements and access to care). At the bottom of the framework are additional evaluations that beneficiaries were asked to make, first about the information they received and the amount of time they had to choose new coverage and, second, about their satisfaction with their new coverage relative to their former plan.

Figure 2
Impact of plan withdrawals on Medicare beneficiaries



CHARACTERISTICS OF INVOLUNTARY DISENROLLEES

Table C.1 in ***Appendix C*** shows the characteristics of the four sample groups of beneficiaries who responded to the survey: beneficiaries who qualified for Medicare due to their age (referred to as "aged") and who lived in a county with a choice of another Medicare HMO; aged

beneficiaries living in a county without another Medicare HMO alternative; beneficiaries who qualified for Medicare due to disability (referred to as "disabled") and lived in a county with a choice; and disabled beneficiaries without a choice of another Medicare HMO. The "Total" column represents weighted data from all four strata. Thus the total columns in tables in this report reflect the weighted mix of those aged and disabled beneficiaries in counties with and without a Medicare HMO (as of January 1, 2002), i.e., in proportion to the composition of the entire population of involuntary disenrollees.

There were a number of significant differences between beneficiaries in the four sample groups. In addition to differences in age, disabled beneficiaries were more likely than aged beneficiaries to be male, non-white, in fair or poor health, to have been hospitalized within the past year, and to be eligible for Medicaid. Aged beneficiaries were less likely to have graduated from high school than disabled beneficiaries.

Table C.1 also provides descriptive statistics for the total sample from the 2001 Survey of Involuntary Disenrollees. The 2002 sample was quite similar to the 2001 sample in terms of age, gender, race/ethnicity, education, and health status. One difference between the two samples was that even fewer members of the 2002 sample lived in a non-metropolitan county than in 2001: 4 percent of the 2002 sample compared to 8 percent of the 2001 sample. Twenty-four percent of all Medicare beneficiaries live in non-metropolitan counties (Achman and Gold, 2002). There was a significant difference between the geographic location of the choice and no-choice strata: only 1 percent of those with a choice of another HMO live in a non-metropolitan area while 17 percent of aged beneficiaries and 21 percent of disabled beneficiaries without a choice of another HMO live in non-metropolitan counties.

INFORMATION ABOUT PLAN WITHDRAWALS

In 2002, half of all beneficiaries indicated that they made their own decisions regarding health insurance, down from 55 percent in 2001. Disabled beneficiaries (those under 65 years of age) were more likely than aged beneficiaries (those 65 years of age and over) to report making decisions without assistance from someone else (***Table C.2***). Sixty-five percent of beneficiaries affected by plan withdrawals in 2002 first found out that their plan would no longer cover them from the plan itself. As was also the case in 2001, the next most common source of information was the media, i.e., newspaper, radio, or television. Beneficiaries with more education were twice as likely to have first heard about their plan's withdrawal from the media than less educated beneficiaries (***Table C.3***). Similarly, beneficiaries who are 65 to 74 years of age and those who are white and non-Hispanic were also far more likely to have heard via the media than beneficiaries 85 years of age and older or beneficiaries who are Hispanic or non-white.

AWARENESS OF COVERAGE OPTIONS

With regards to whether or not beneficiaries believed that there was another Medicare HMO available to them, a little over half of beneficiaries who live in an area with another HMO thought that there was one available, whereas less than half of beneficiaries in areas without another HMO indicated that there was no other Medicare HMO available (***Table C.4***). In 2002, more beneficiaries did not answer this question or indicated that they did not know whether or not there was another Medicare HMO available to them than in 2001. Beneficiaries in counties with another Medicare HMO available who stated that no other HMOs are available may be correct. Some HMOs are at

capacity and not accepting new enrollments,[7] and others only cover parts of counties (particularly group and staff models). Also, CMS' definition of "choice" does not include the availability of cost contract or PFFS plans or of HMO coverage that is offered to beneficiaries by a current or former employer or via participation in Medicaid. In addition, some beneficiaries may not understand that if they continue to see a provider that was affiliated with their former HMO, their services may now be covered under the Original FFS Medicare (otherwise referred to as Original Medicare).

Responses to whether or not there was another Medicare HMO available were combined with residence in a choice/no-choice county to create a variable reflecting whether a respondent "knew" whether there was another Medicare HMO available in their county, i.e., if a respondent indicated that a) there was another Medicare HMO available and they lived in a choice county or that b) there was not another Medicare HMO available,[8] they were assigned a value of 1. Conversely, if they indicated that there was another Medicare HMO available but they lived in a no-choice county,[9] or they did not respond to this question or responded "Don't know," then they were assigned a value of 0. Multivariate analysis of knowing whether another Medicare HMO was available indicated no significant differences among specific demographic subgroups (***Table C.5***). However, beneficiaries who were seeing a specialist at the time of the plan withdrawals, who first found out about the plan withdrawals from a provider (rather than the plan), whose former plan provided coverage for prescription drugs, or who lived in areas with high Medicare managed care market penetration were more likely to know whether there was another Medicare HMO available.

Awareness of the availability of supplemental insurance was similar in 2002 to 2001, with 7 in 10 beneficiaries indicating that they were aware of the availability of supplemental insurance. From the bivariate analyses reported in ***Table C.6***, disabled (those under age 65), less-educated, and non-white beneficiaries, those in poor health, and those who indicated that they did not have enough information about their coverage options were more likely to indicate that supplemental insurance was not available. Reponses to the question on availability of supplemental options may reflect beneficiary experiences with health screening, i.e. some may have been turned down, and so the insurance is "unavailable" although it is likely that some of these responses reflect misunderstandings on the part of respondents about what options are available to them.

When other factors were taken into consideration in multivariate analysis (***Table C.7***), all of these factors (except for education) continued to be associated with a decreased likelihood of reporting the availability of supplemental insurance. In addition, compared to people who first found out about the plan withdrawal from the plan itself, people who first found out from the media were also less likely to report that supplemental insurance was available. Beneficiaries who were seeing a specialist, who first found out about the plan withdrawals from a provider, a family member, or a friend, whose former plan covered prescription drugs, or who lived in CMS Regions VII, VIII, IX, and X (Kansas City, Denver, San Francisco, and Seattle) were more likely to report availability of supplemental insurance.

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[7] Health plans can request capacity limits be established prospectively to be applied when their enrollment reaches a certain level or they can request that their enrollment level be limited to the number of beneficiaries currently enrolled. Consequently, at any point in time a plan with "capacity limits" may or may not actually be accepting new enrollees.

[8] Beneficiaries in counties with another Medicare HMO available who stated that no other HMOs are available may be correct. Some HMOs are at capacity and not accepting new enrollments, and others only cover parts of counties (particularly group and staff models).

[9] The definition of "choice" does not account for the availability of cost contract or private fee-for-service plans or of HMO coverage that is offered to beneficiaries by a current or former employer or via participation in Medicaid. Consequently, there is a possibility that some of these respondents were correct.

Forty-three percent of beneficiaries thought that when their plan stopped covering them they would be covered under Original Medicare (***Table C.4***). This represents a decrease from the previous year, when 48 percent of beneficiaries thought they would be covered under Original Medicare. One-third of the beneficiaries responding to the 2002 survey thought that they would end up with no health insurance, up from 28 percent in 2001. This represents a decrease in understanding among beneficiaries about what would happen when their plan withdrew.

From beneficiaries' responses to the question about what would happen if they did not change insurance when their plan stopped covering them, we derived a measure of the percentage who understood what would happen when their plan withdrew (***Table C.6***). Those who thought that they would be covered by the Original Medicare plan, covered through their current or former employer, or who thought they would be able to select a new plan understood what would happen.[10] Conversely, those who thought that they would end up with no health insurance or that they would be automatically enrolled in another HMO apparently did not understand the implications of their plan's decision to stop covering them.[11] It is possible that some beneficiaries do not think of Medicare as "insurance" and consequently indicated that they thought they would end up with no insurance rather than indicating they would end up with Original Medicare coverage.[12]

Half of beneficiaries appeared to understand exactly what would happen when their plan left the Medicare program (***Table C.6***). Beneficiaries with less understanding of the implications of plan withdrawals include African-Americans and other non-whites, females, those with less than a 9th grade education, those who were hospitalized in the past year, and those who first found out about the plan withdrawals from the media (***Table C.8***). Beneficiaries who were more likely to understand what would happen to them when their plan withdrew include those with education beyond high school, those currently seeing a specialist, those who recalled receiving a letter about the withdrawal from their former plan, and those living in regions I, II, IV, VI, and IX (, Boston, New York, Atlanta, Dallas, and San Francisco).

Figure 3 provides a summary of the findings about beneficiaries' awareness of options.

CONCERNS ABOUT PLAN WITHDRAWALS

One set of questions in the Survey of Involuntary Disenrollees addressed the concerns that beneficiaries faced when they found out that their plan was withdrawing from or reducing its service area in the M+C program. Beneficiaries were asked to indicate how concerned they were about having to change their personal doctor or nurse, about no longer being able to pay for care, and about not being able to get health care that they needed. Half of all beneficiaries were very concerned about paying for care or about getting needed health care (***Table C.9***). The level of concern among beneficiaries in 2002 was similar to the level of concern in 2001. Disabled beneficiaries reported more concerns than aged beneficiaries. Beneficiaries in areas with a choice of another Medicare HMO were more concerned about having to change providers than those in areas without an HMO alternative. The highest level of concern about no longer being able to pay for health care was among disabled beneficiaries in areas without a choice of another HMO: three out

[10] Those who thought they would "have to purchase supplemental insurance" may indicate a belief on the part of the respondent that prudence or financial necessity demanded the purchase of supplemental insurance rather than it being a legal or program requirement. Consequently, these individuals were also considered to have understood what would happen.

[11] Those who did not respond to this question or whose responses could not be coded were also classified as not understanding.

[12] While question 10 (see Appendix D) did not specifically indicate that the response options were mutually exclusive, less than 1 percent of respondents indicated multiple responses to this item.

of four of these beneficiaries were very concerned about this potential impact of the plan withdrawals.

Figure 3
Summary of findings about beneficiaries' awareness of options

	More likely to know whether another Medicare HMO available	More likely to know if supplemental insurance available	More likely to know what would happen after withdrawal	Less likely to know whether another Medicare HMO available	Less likely to know if supplemental insurance available	Less likely to know what would happen after withdrawal
Beneficiary characteristics	Seeing a specialist Knew about former drug coverage (vs. did not know)	Seeing a specialist (vs. no specialist) Knew about former drug coverage (vs. did not know)	Male Education beyond high school (vs. high school graduate) Seeing a specialist	Not seeing a specialist	Disabled (vs. ages 65-74) African-American (vs. white non-Hispanic) Hispanic (vs. white non-Hispanic) Poor health (vs. excellent health)	Female African-American (vs. white) Other non-white (vs. white non-Hispanic) < grade 9 education Hospitalized in past year Not seeing a specialist
Information about plan withdrawal	Provider was first source (vs. plan) Received letter from plan	Provider, family, or friend was first source (vs. plan) Received letter from plan	Received letter from plan	No recall of letter from plan	Media was first source (vs. plan) No recall of letter from plan	Media was first source (vs. plan) No recall of letter from plan
Market characteristics	High MMC[1] market penetration (vs. minimal) Higher M+C payment rates (vs. average rate)	Regions VII, VIII, IX, X (Kansas City, Denver, San Francisco, Seattle) (vs. Region III-Philadelphia)	Regions I, II, IV, VI, IX (Boston, New York, Atlanta, Dallas, San Francisco) (vs. Region III-Philadelphia)	Region VII, VIII, X (Kansas City, Denver, Seattle) Lower M+C payment rate (vs. average rate)	N.S.[2]	N.S.

[1]MMC = Market and Mergers Commission.
[2]N.S. = No significant findings.
SOURCE: Logistic regression analyses reported in Tables C.5, C.7 and C.8 in Appendix C.

Bivariate analyses of the relationship between concerns and beneficiary characteristics showed that in addition to younger disabled beneficiaries, non-whites and Hispanics, those in poor or fair health, and those with less education were more likely to be very concerned about having to change providers and about getting and paying for care (***Table C.10***). The relationship between disability, having less than a ninth-grade education, and being in less than optimal health and having increased concerns remained even when other factors were held constant in a multivariate model (***Table C.11***). Others who were more likely to be very concerned about getting and paying for care included those who had help completing the survey, those currently seeing a specialist, and those in areas with the highest payment rates to Medicare HMOs. The oldest beneficiaries (those 85 years of age and over) were less likely than younger beneficiaries to be very concerned.

EVALUATION OF INFORMATION AND TIME TO CHOOSE

Thirty-five percent of beneficiaries indicated that they did not receive enough information about their coverage options when their plan stopped covering them (***Table C.12***). Disabled beneficiaries were less likely than aged beneficiaries to indicate that they received enough

information. Beneficiaries who had someone else make their health insurance decisions, who did not report that supplemental insurance was available, who were very concerned about getting and paying for care, or who did not understand what would happen when their plan withdrew were also less likely to indicate that they received enough information (***Table C.13***).

Beneficiaries were less satisfied with the amount of time they had to choose their new coverage in 2002 than they were in 2001. In 2001, 32 percent reported being not very or not at all satisfied with the amount of time, whereas in 2002 this increased to 37 percent of beneficiaries (***Table C.12***). Factors associated with satisfaction with the amount of time to choose included first hearing about the plan withdrawal from the plan itself, living in an area with high Medicare+Choice market penetration, and not being very concerned about getting and paying for care (***Table C.14***).

Figure 4 provides a summary of the findings about beneficiaries' concerns about the plan withdrawals, their satisfaction with the amount of time they had to choose new coverage, and whether or not they had enough information about their coverage options.

NEW COVERAGE ARRANGEMENTS

With respect to beneficiaries' new coverage arrangements after their plan's withdrawal from the Medicare program, analysis of results of the 2001 Survey of Involuntary Disenrollees indicated some significant discrepancies between beneficiaries' reports of their coverage and CMS' administrative records. Consequently, a new algorithm was used for determining beneficiaries' new coverage arrangements. First, CMS administrative records were reviewed to determine whether beneficiaries enrolled in another Medicare HMO or in a Medicare PFFS plan as a result of their plan withdrawal. If no such enrollment was found, beneficiaries' reports of other coverage were examined in a hierarchical manner to determine other coverage arrangements: this algorithm looked first for reports of enrollment in Medicaid, then for reports of coverage through a current or former employer, then for reports of having supplemental insurance. If no M+C enrollments were identified and beneficiaries did not report having any other coverage, then they were assumed to have only Original Medicare coverage. This algorithm was applied to both the 2001 and 2002 data to provide the comparable results displayed in ***Table C.15*** and ***Figures 5a*** and ***b***.

Overall in 2002, 34 percent of the involuntary disenrollees enrolled in another Medicare HMO, less than 1 percent joined a PFFS plan, 5 percent reported enrollment in Medicaid, 11 percent reported coverage through an employer, 34 percent reported having supplemental insurance, and 16 percent reported no other coverage and were assumed to have only Original Medicare. These percentages were similar to the new coverage arrangements for the 2001 involuntary disenrollees. There were, however, significant differences in new coverage arrangements between the beneficiaries in the four sample groups, with 40 and 45 percent, respectively, of aged and disabled beneficiaries in areas with choice of another HMO enrolling in an HMO, compared to a negligible number of beneficiaries in areas without another HMO. Aged beneficiaries were more likely than disabled beneficiaries to report having supplemental insurance. Aged and disabled beneficiaries in areas without another Medicare HMO were more likely to report having supplemental insurance or to have Original Medicare only than beneficiaries in areas with another HMO. While less than 1 percent of involuntary disenrollees in areas with a choice of another HMO joined a PFFS plan, 8 percent of disabled beneficiaries in areas without another Medicare HMO joined a PFFS plan.

Figure 4
Summary of findings about beneficiary concerns, satisfaction, and information

	Less likely to be very concerned about getting and paying for care	More likely to be satisfied with amount of time to choose new coverage	More likely to be satisfied with information	More likely to be very concerned about getting and paying for care	Less likely to be satisfied with amount of time to choose new coverage	Less likely to be satisfied with information
Beneficiary characteristics	85 years and over (vs. 65-74) Not seeing a specialist Did not have help completing survey	N.S.[1]	Ages 75-84 (vs. 65-74) Make decisions alone or with help (vs. someone else) Knew about former drug coverage (vs. not knowing)	Disabled (vs. ages 65-74) < grade 9 education (vs. high school graduate) Poor to good health (vs. excellent) Needed help to complete survey Seeing a specialist	N.S.	N.S.
Information about plan withdrawal	N.S.	Provider, family, friend, or media was first source (vs. plan)	Received letter from plan	N.S.	N.S.	Provider was first source (vs. plan) No recall of letter from plan
Market characteristics	N.S.	Region VII, VIII, X (Kansas City, Denver, San Francisco) (vs. Region III-Philadelphia) High MMC[2] market penetration (vs. minimal)	N.S.	Higher M+C payment rate (vs. average rate)	Higher M+C payment rate (vs. average rate)	N.S.
Awareness of options	N.S.	Knew supplemental insurance available	Knew supplemental insurance available Understood what would happen	N.S.	Did not know if supplemental insurance available	Did not know if supplemental insurance available Did not understand what would happen
Concerns		Not very concerned about getting/ paying for care	Not very concerned about getting/ paying for care		Very concerned about getting/ paying for care	Very concerned about getting/ paying for care

[1]N.S. = No significant findings.
[2]MMC = Market and Mergers Commission.
SOURCE: Logistic regression analyses reported in Tables C.11, C.13, and C.14 in Appendix C.

Figure 5a
New coverage arrangements of aged involuntary disenrollees (2002)

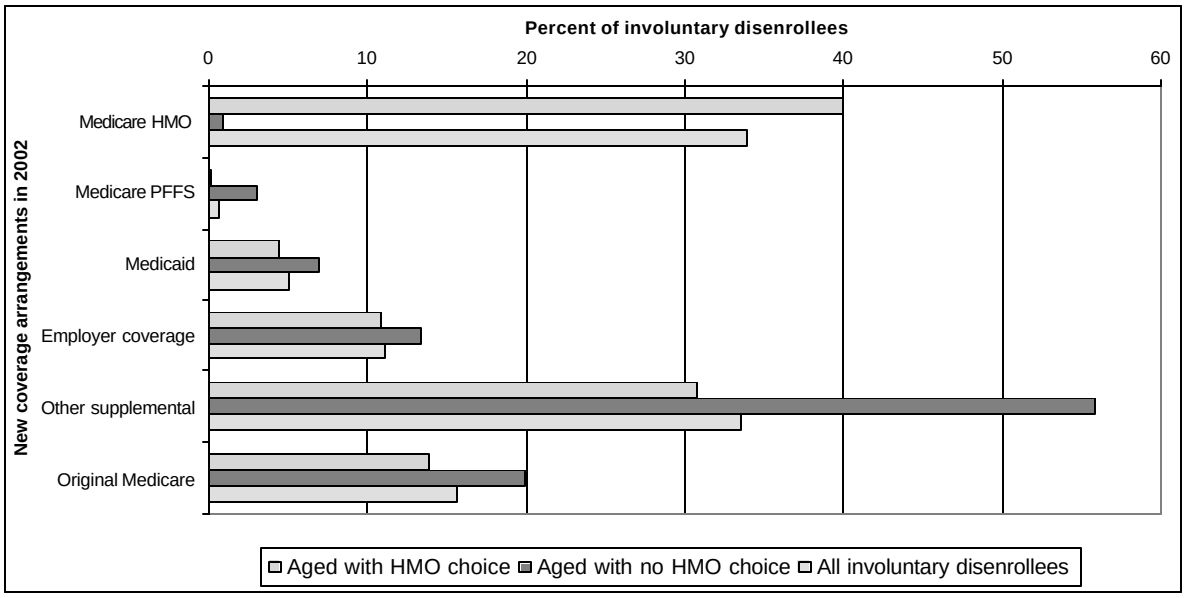
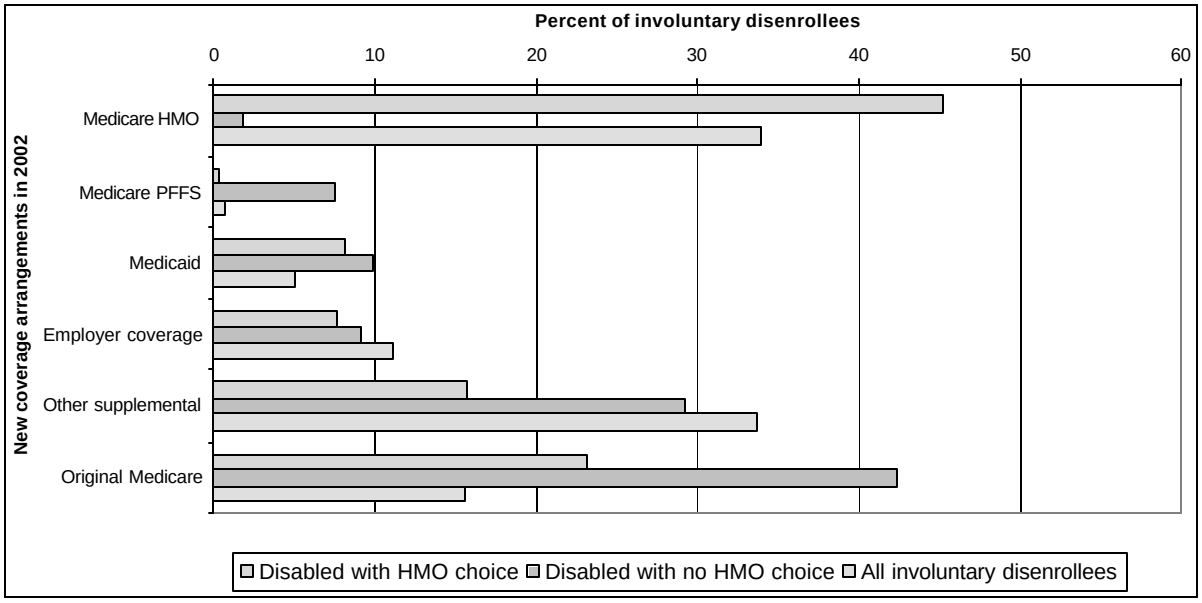


Figure 5b
New coverage arrangements of disabled involuntary disenrollees (2002)



Approximately 1,000, or 23 percent, of all respondents reported that they enrolled in another Medicare HMO, but CMS records did not confirm their HMO enrollment. These respondents were treated in the same way as other respondents where no record of Medicare HMO enrollment was found in CMS files: 2 percent (of the 1,000) were found to have enrolled in a Medicare PFFS plan, 9 percent reported coverage under Medicaid, 22 percent reported coverage through an employer, 53 percent reported having other supplemental insurance, and no other coverage beyond Original Medicare was identified by 14 percent of these respondents.

A multivariate model, excluding those with coverage through an employer or via Medicaid, of enrolling in another Medicare HMO (***Table C.16***) suggests that disabled beneficiaries (under 65), those who first heard about their plan's withdrawal from the media, those who recalled receiving a letter about the withdrawal from the plan, those living in areas with higher Medicare managed care penetration, those in Region III (Philadelphia), those who knew that a Medicare HMO was available, and those who were very concerned about getting and paying for care were more likely to enroll in another HMO. Those who were less likely to join another HMO included those who did not recall receiving a letter from the plan, those in areas with minimal Medicare managed care market penetration, those in all regions except Regions III, VII, VIII, and X (Philadelphia, Kansas City, Denver, and San Francisco), those who did not know if there was another HMO available, those who reported that supplemental insurance was available, those who were not very concerned about getting and paying for care, and those who reported not having enough information about their coverage options.

Table C.17 provides the results of a logistic regression of having supplemental insurance after plan withdrawal, excluding those with coverage through an employer or through Medicaid. This multivariate model suggests that disabled and African-American beneficiaries, those who had someone else make their health insurance decisions, those who were not currently seeing a specialist, those in metropolitan counties, those in areas with high Medicare managed care market penetration and low and high payment rates to Medicare HMOs, those in Region III (Philadelphia), those who did not report that supplemental insurance was available, those who understood what would happen, those who were very concerned about getting and paying for care, and those reporting having enough information were less likely to report having supplemental insurance. Beneficiaries who made their own health insurance decisions or made their decisions with someone else, those seeing a specialist, those in non-metropolitan counties, those in regions other than Region III (Philadelphia), those who reported that supplemental insurance was available, those who did not understand what would happen, and those who reported not having enough information were more likely to report having supplemental insurance.

The most common reason cited for not having supplemental insurance was that it cost too much (***Table C.18***). Sixty-two percent of beneficiaries who reported that they did not have supplemental insurance said that cost was the reason. The next most frequent reason cited was that they did not need supplemental insurance. Aged beneficiaries were more than twice as likely to report not needing supplemental insurance than disabled beneficiaries. Disabled beneficiaries were just as likely to report having applied for supplemental insurance and being rejected as to say that they did not need supplemental insurance.

Female beneficiaries, those with education beyond high school, those currently seeing a specialist, those living in areas with high Medicare HMO penetration, those living in Region III (Philadelphia), those who knew that supplemental insurance was available, those who knew that a Medicare HMO was available, and those who did not understand the implications of the plan withdrawals[13] were less likely to end up only with Original Medicare coverage (***Table C.19***). This model excluded beneficiaries with coverage through an employer or through Medicaid.

[13] This finding is not observed when looking only at a bivariate analysis of new coverage arrangements for those who understood and those who did not understand the implications of the withdrawals, i.e., it only occurs in a multivariate context when many other variables such as education, health status, region, and health care market conditions are taken into account. Beyond this, the authors were unable to provide an explanation for this finding.

Beneficiaries were asked about whether they had prescription drug coverage under their former plan and under their new coverage. ***Table C.20*** provides the results of a multivariate model predicting the likelihood of having coverage for prescription drugs after plan withdrawal. Compared to white non-Hispanics, African-Americans and those of other racial groups were more likely to report having prescription drug coverage after the plan withdrawals as were those whose former plan paid for the cost of medicines, those who heard about the plan withdrawals from family or friends, those who knew if a Medicare HMO was available, and those who reported having enough information about their coverage options. Compared to those reporting excellent health, people in poor health were less likely to report having prescription drug coverage as were those who did not have this coverage in their former plan and those who live in regions I, II, III, IV, V, and IV (Boston, New York, Atlanta, Chicago, and Dallas) those who did have enough information, and those who did not know if another Medicare HMO was available.

Figure 6 provides a summary of the findings about involuntary disenrollees' new coverage arrangements.

FINANCIAL IMPLICATIONS

In 1999, 61 percent of all Medicare beneficiaries had access to a M+C coordinated care plan with zero premiums. This percentage has declined in each of the three subsequent years: to 53 percent in 2000, 39 percent in 2001, and 32 percent in 2002. In 2001, 46 percent of M+C enrollees were in zero-premium plans; however, these enrollees still had to continue to pay their Medicare Part B premiums (CMS, June 2002). Fifty-five percent of beneficiaries reported having to pay more for premiums after their plan withdrew in 2002, similar to the proportion of beneficiaries reporting this in 2001 (***Table C.21***). Aged beneficiaries in areas without another HMO alternative were the most likely to report having to pay higher premiums. Bivariate analyses indicated that the likelihood of having to pay more increased with the level of education and with having supplemental insurance (***Table C.22***). These relationships continued in the multivariate analysis (***Table C.23***). Others having to pay more for premiums included those currently seeing a specialist, those whose former plan paid the cost of medicines, those living in Region III (Philadelphia), those who reported that supplemental insurance was available, those who knew if a Medicare HMO was available, and those enrolled in a PFFS plan. Beneficiaries who were less likely to report having to pay more for premiums included those who had been hospitalized in the past year, those not currently seeing a specialist, those in regions other than Region III (Philadelphia), and those who had Original Medicare only. In theory respondents who have Medicaid or are Medicare-only should not pay any premiums post-plan withdrawal; however, these respondents may be confused about the meaning of premium, or may have answered in reference to their Part B premium rather than their HMO premium.

The percentage of beneficiaries reporting that their former plan paid for the cost of medicines decreased significantly from 2001 to 2002, from 74 percent to 63 percent (***Table C.21***). This parallels the general trend among plan benefits in the M+C program. In 2000, 64 percent of Medicare beneficiaries had access to a plan with drug coverage, compared to 53 percent in 2001 and 50 percent in 2002 (CMS, June 2002). Similarly, while 53 percent of involuntary disenrollees in 2001 reported that their new coverage paid for prescription medicines, this number decreased to 47 percent in 2002. The multivariate model predicting who would have to pay more for prescription drugs after plan withdrawal (***Table C.24***) showed that those in poor health, those whose former

plan paid for the cost of medicines, those in regions other than Region III (Philadelphia), those in areas

Figure 6
Summary of findings about involuntary disenrollees' new coverage arrangements

	More likely to be enrolled in another Medicare HMO	More likely to have supplemental insurance	More likely to have Original Medicare only	Less likely to be enrolled in another Medicare HMO	Less likely to have supplemental insurance	Less likely to have Original Medicare only
Beneficiary characteristics	Disabled < 65 (vs. 65-74)	Seeing a specialist	Male Some high school (vs. high school graduate) Not seeing a specialist Make decisions alone (vs. someone else)	N.S.[1]	Disabled < 65 (vs. 65-74) African-American (vs. white non-Hispanic) Not seeing a specialist Make decisions alone or with help (vs. someone else)	Female Education beyond high school (vs. high school graduate)
Information about plan withdrawal	Media was first source of information (vs. plan) Received letter from plan Reported having enough information	Reported not having enough information	N.S.	Reported not having enough information No recall of letter from plan	Reported having enough information	N.S.
Market characteristics	Limited to high MMC[2] market penetration (vs. minimal) Region III (Philadelphia)	N.S.	Metropolitan county All regions other than Region III (Philadelphia)	All regions other than Region III (Philadelphia)	Metropolitan county	High MMC market penetration (vs. minimal)
Awareness of options	Knew whether another Medicare HMO available Did not know if supplemental insurance available	Knew supplemental insurance available Did not know whether another Medicare HMO available	Did not know whether another Medicare HMO available Did not know if supplemental insurance available Understood what would happen	Did not know whether another Medicare HMO available Knew supplemental insurance available	Did not know if supplemental insurance available Knew whether another Medicare HMO available	Knew whether another Medicare HMO available Knew supplemental insurance available Did not understand what would happen
Concerns	Very concerned about getting/ paying for care	N.S.	N.S.	Not very concerned about getting/ paying for care	N.S.	N.S.

[1]N.S. = No significant findings.
[2]MMC = Market and Mergers Commission.
SOURCE: Logistic regression analyses reported in Tables C.16, C.17, and C.19 in Appendix C.

where payment rates to Medicare HMOs were highest, those who reported that supplemental insurance was available, those who knew if a Medicare HMO was available, and those enrolled in PFFS or having supplemental insurance were more likely to have to pay more for prescription drugs after their former plan withdrew. Those who lived in areas with higher Medicare HMO penetration, those whose former plan did not cover prescription drugs, and those reporting enrollment in Medicaid were less likely to have to pay more for prescription drugs after their plan withdrew.

Figure 7 provides a summary of findings about the financial implications of the plan withdrawals for beneficiaries.

Figure 7
Summary of findings about the financial implications of plan withdrawals

	Less likely to be paying more for premiums	Less likely to be paying more for prescription drugs	More likely to be paying more for premiums	More likely to be paying more for prescription drugs
Beneficiary characteristics	Hospitalized in past year Not seeing a specialist	Former plan did not pay for drugs (vs. did not know former coverage)	Education beyond high school (vs. high school graduate) Not hospitalized in past year Seeing a specialist Former plan paid coverage for drugs (vs. did not know former coverage)	Poor health (vs. excellent) Former plan paid coverage for drugs (vs. did not know former coverage)
Information about plan withdrawal	N.S.[1]	N.S.	N.S.	N.S.
Market characteristics	All regions other than Region III (Philadelphia) MMC[2] payment rate of $525-$600 (vs. average)	Region III (Philadelphia) Limited to high MMC market penetration (vs. minimal) Low MMC payment rate (vs. average)	Region III (Philadelphia)	All regions other than Region III (Philadelphia)
Awareness of options	N.S.	N.S.	Knew whether another Medicare HMO available (vs. did not know) Knew supplemental insurance available (vs. did not know)	N.S.
Concerns	N.S.	N.S.	N.S.	N.S.
New coverage arrangement	Original Medicare only (vs. Medicare HMO)	N.S.	Medicare PFFS or have supplemental insurance (vs. Medicare HMO)	N.S.

[1]N.S. = No significant findings.
[2]MMC = Market and Mergers Commission.
SOURCE: Logistic regression analyses reported in Tables C.23 and C.24 in Appendix C.

IMPLICATIONS FOR CARE

Fewer involuntary disenrollees reported having to change their personal doctor or nurse in 2002 than in 2001: 16 percent down from 21 percent (***Table C.25***). For those who did have to change providers, about 19 percent found this to be a big problem in 2002, the same as in 2001. Again, as in 2001, about 40 percent of beneficiaries in 2002 reported that they were currently seeing a specialist when their former plan withdrew from the Medicare program. Of these beneficiaries who were seeing a specialist, only 14 percent had to stop seeing this specialist when their plan withdrew in 2002, compared to 22 percent in 2001. Disabled beneficiaries (those under 65 year of age) and non-white or Hispanic beneficiaries were more likely to have to change providers or stop seeing a specialist (***Table C.26***). In the multivariate model (***Table C.27***), the only significant factors associated with having to change providers were Medicare managed care market penetration (people in areas with higher penetration were less likely to have to change); region (those in the Philadelphia region [Region III] were less likely than those in other regions to have to change); and new coverage (those enrolling in another Medicare HMO were more likely to have to change providers).

In the multivariate model examining the likelihood of having to stop seeing a specialist if currently seeing one, male beneficiaries, those who made their health insurance decisions alone or with someone else, and those who were less satisfied with the time they had to choose were more likely to have to stop seeing their specialist (***Table C.28***). Female beneficiaries and those who had supplemental insurance or coverage through an employer were less likely to have to stop seeing a specialist.

Figure 8 provides a summary of the findings about the impact of plan withdrawals on beneficiaries' provider arrangements.

Figure 8
Summary of findings about the impact of plan withdrawals on provider arrangements

	Less likely to have change personal doctor or nurse	Less likely to have stop seeing specialist	More likely to have change personal doctor or nurse	More likely to have stop seeing specialist
Beneficiary characteristics	N.S.[1]	Female	N.S.	Male Make decisions alone or with help (vs. someone else)
Information about plan withdrawal	N.S.	N.S.	N.S.	Did not report having enough information (vs. reported enough)
Market characteristics	Region III (Philadelphia) Limited to high MMC[2] market penetration		All regions other than Region III (Philadelphia) Minimal MMC market penetration	Regions IV, VI, VII, VIII, X (Atlanta, Dallas, Kansas City, Denver, Seattle) (vs. Region III- Philadelphia) High M+C payment rate (vs. average)
Awareness of options	N.S.	N.S.	N.S.	N.S.
Concerns	N.S.	N.S.	N.S.	Somewhat or not very satisfied with time to choose (vs. extremely satisfied)
New coverage arrangement	All coverage other than Medicare HMO	Coverage through employer or supplemental insurance (vs. Medicare HMO)	Medicare HMO	N.S.

[1]N.S. = No significant findings.
[2]MMC = Market and Mergers Commission.

SOURCE: Logistic regression analyses reported in Tables C.27 and C.28 in Appendix C.

Eight percent of involuntary disenrollees reported that they had trouble getting the health care they needed or wanted after their former plan withdrew from the Medicare program in 2002 (***Table C.29***). This was down slightly from the 11 percent reporting having trouble in 2001. Similarly, the 18 percent of beneficiaries who reported delaying seeking care in 2002 due to cost was down from 22 percent in 2001. Disabled beneficiaries were far more likely than aged beneficiaries to report having trouble getting care, delaying care due to cost, or not getting prescribed medicines. This was found in both the bivariate analysis (***Table C.30***) and the multivariate analyses (***Tables C.31-C.33***). Others who more frequently had trouble getting care included those living in areas where the Medicare payment rate to HMOs was higher, those living in Regions IV and VI (Atlanta and Dallas), those who reported not having enough information about their coverage options, and those who ended up with Original Medicare only. In addition to disabled beneficiaries, others who more frequently delayed care due to cost included those with less education, those with poor to good health, those who make their health insurance decisions alone, those in Regions IV

and VI (Atlanta and Dallas), those who were very concerned about what would happen when their plan withdrew, those who did not have enough information, those who enrolled in a PFFS plan, and those with Original Medicare coverage only.

Figure 9 provides a summary of findings about the impact of plan withdrawals on beneficiaries' access to care.

Figure 9
Summary of findings about the impact of plan withdrawals on access to care

	Less likely to have had trouble getting care	Less likely to have delayed care due to cost	Less likely to not get prescribed medicines	More likely to have trouble getting care	More likely to have delayed care due to cost	More likely to not get prescribed medicines
Beneficiary characteristics	N.S.[1]	85 years and over (vs. 65-74)	85 years and over (vs. 65-74) Not seeing a specialist	Disabled < 65 (vs. 65-74)	Disabled < 65 (vs. 65-74) < grade 9 education (vs. high school grad) Poor to good health (vs. excellent) Make decisions alone (vs. someone else)	Disabled < 65 (vs. 65-74) Hispanic (vs. white non-Hispanic) Education beyond high school (vs. high school graduate) Poor to very good health (vs. excellent) Seeing a specialist
Information about plan withdrawal	Reported having enough information	Reported having enough information	Reported having enough information	Did not report having enough information	Did not report having enough information	Did not report having enough information
Market characteristics	N.S.	N.S.	N.S.	Regions IV and VI (Atlanta and Dallas) (vs. Region III-Philadelphia) Higher M+C payment rates (vs. average)	Regions IV and VI (Atlanta and Dallas) (vs. Region III-Philadelphia)	Higher M+C payment rates (vs. average)
Awareness of options	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Concerns	N.S.	Not very concerned about getting and paying for care	Not very concerned about getting and paying for care	N.S.	Very concerned about getting and paying for care	Very concerned about getting and paying for care Not at all satisfied with time to choose (vs. extremely satisfied)
New coverage arrangement	Covered through employer (vs. Medicare HMO)	N.S.	N.S.	Original Medicare only (vs. Medicare HMO)	Medicare PFFS and Original Medicare only (vs. Medicare HMO)	Original Medicare only (vs. Medicare HMO)

[1]N.S. = No significant findings.

SOURCE: Logistic regression analyses reported in Tables C.31C.33 in Appendix C.

SATISFACTION WITH NEW COVERAGE

Although 30 percent of beneficiaries reported being less satisfied with their health insurance after the plan withdrawals in 2002, this proportion has declined somewhat from 2001, when 37 percent were less satisfied with their new coverage (***Table C.34***). Disabled beneficiaries were clearly less satisfied with their new coverage than aged beneficiaries, particularly those living in areas without a choice of another HMO. Beneficiaries reporting poor or fair health, those whose former plan paid the cost of medicines, those in metropolitan counties, those who understood what would happen, those who were very concerned about getting and paying for care, those who reported not having enough information, and those who were not satisfied with the amount of time they had to choose new coverage were more likely to report being less satisfied with their new coverage (***Table C.35***).

Figure 10 provides a summary of findings about involuntary disenrollees' new coverage compared to their coverage under their former plan.

Figure 10
Summary of findings about beneficiaries' satisfaction with new coverage

	Less likely to be less satisfied with new coverage	More likely to be less satisfied with new coverage
Beneficiary characteristics	85 years and over (vs. 65-74) African-American (vs. white non-Hispanic)	Poor to fair health (vs. excellent) Former plan paid for drugs (vs. do not know whether former plan paid for drugs)
Information about plan withdrawal	Reported having enough information	Did not report having enough information
Market characteristics	Non-metropolitan county	Metropolitan county Regions I, IV, VI, VII, VIII, IX, X (Boston, Atlanta, Dallas, Kansas City, Denver, San Francisco, Seattle) (vs. Region III- Philadelphia) Lower M+C payment rate (vs. average)
Awareness of options	Did not know whether another Medicare HMO available Did not understand what would happen	Knew whether another Medicare HMO available Understood what would happen
Concerns	Not very concerned about getting and paying for care	Very concerned about getting and paying for care Not at all or not very satisfied with time to choose (vs. extremely satisfied with time to choose)
New coverage arrangement	N.S.[1]	N.S.

[1]N.S. = No significant findings.
SOURCE: Logistic regression analysis reported in Table C.35 in Appendix C.

DISCUSSION AND IMPLICATIONS

As was true in 2001, the characteristics of involuntary disenrollees living in areas with and without a choice of another HMO in 2002 were quite similar, with one major exception: less than 1 percent of beneficiaries with a choice of another HMO lived in non-metropolitan counties, while 18 percent of beneficiaries without another HMO option lived outside of metropolitan areas. Ninety-seven percent of the involuntary disenrollees surveyed lived in a metropolitan county: 86 percent of these metropolitan residents had a choice of another Medicare HMO, whereas only 19 percent of the involuntary disenrollees living in a non-metropolitan area had another HMO as an option. This difference highlights the continued disparity noted by Achman and Gold (2002) in choices available to metropolitan and non-metropolitan beneficiaries.

Differences between survey respondents in the aged strata (65 years of age and over) and those in the disabled strata (those under 65 years of age) were evident. As would be expected, and similar to findings in 2001, disabled beneficiaries were more likely to report being in poor or fair health, to have been hospitalized in the past year, and to be dually eligible for Medicaid. Disabled beneficiaries were less likely to be white than aged beneficiaries.

The findings show that there are some clear differences between involuntary disenrollees in vulnerable and less vulnerable subgroups regarding their understanding of the options available to them and the implications of plans withdrawing from the Medicare program. ***Figure 11*** provides a summary of the key findings for four vulnerable subgroups: disabled beneficiaries (under 65 years of age) compared to those 65 to 74 years of age, nonwhite or Hispanic beneficiaries compared to white non-Hispanics, beneficiaries with less than a ninth-grade education compared to high school graduates, and beneficiaries in poor health compared to those in excellent health.

Figure 11
Summary of findings about vulnerable subgroups

	Disabled under 65 years of age (compared to those 65-74 years of age)	Non-white or Hispanic (compared to white non-Hispanics)	Less than 9th grade education (compared to high school graduates)	Poor health (compared to those in excellent health)
Less likely to know if supplemental insurance available	v	v		v
Less likely to know what would happen after plan withdrew		v	v	
More likely to be concerned about getting and paying for care	v		v	
More likely to enroll in another Medicare HMO	v			
Less likely to have supplemental insurance	v	v		
More likely to have trouble getting care	v			
More likely to have delayed care due to cost	v		v	
More likely not to get prescribed medicines	v	v (Hispanics)		v
More likely to be less satisfied with new coverage				v

SOURCE: Logistic regression analyses reported in Tables C. 7, C.8, C.11, C.16, C.17, C.31, C.32, C.33, and C.35 in Appendix C.

As was the case in 2001, letters from the non-renewing plans were by far the most frequent first source of information about the plan withdrawal for the majority of disenrollees. The media (TV, radio, or newspaper) were the next most frequent source of information. The information provided by plans appeared to the most effective means of communicating with beneficiaries about the implications of the plan withdrawals. Holding all other factors constant, beneficiaries who remembered receiving a letter from the plan were more likely to believe that they had enough information. Conversely, beneficiaries who first found out about the plan withdrawals from the media were less likely to know if supplemental insurance was available and to understand what would happen to their coverage when their plan stopped covering them. Whether or not a beneficiary felt they had enough information about their coverage options when their plan withdrew turned out to be related to a number of other outcomes of the plan withdrawals. Beneficiaries who reported having enough information were more likely to have enrolled in another Medicare HMO, to have less trouble getting care, to be less likely to have delayed care due to cost, to be more likely to get their prescribed medicines, and were more likely to be satisfied with their new coverage in comparison to their former plan. However, a note of caution: it is necessary to stress that this study only suggests, but does not prove, a causal relationship between information and less negative outcomes from the plan withdrawals. Beneficiaries responded to these questions at only one point in time, so it is possible that, for example, the reason for a beneficiary reporting that they had enough information was because they had not had any trouble getting care since their plan withdrew.

We asked beneficiaries about their level of concerns when they heard that their plan was going to stop covering them. Approximately three out of every four beneficiaries reported that they were somewhat or very concerned about being able to pay for health care when their plan withdrew from the Medicare program. This is similar to results from 2001. A similar, but not entirely overlapping, proportion of beneficiaries were also concerned about getting care while concerns about having to change providers were not quite as widespread but still considerable. Again, as we found in 2001, the more vulnerable subgroups, including the disabled, the less educated, people in the all other racial group (other than white non-Hispanic) or Hispanic, and those in fair or poor health, were disproportionately affected. Beneficiaries in non-metropolitan areas with low Medicare managed care penetration continued to be more concerned by the plan withdrawals. Having enough information reduced but did not eliminate concerns regarding the plan withdrawals.

In the report from the 2001 Survey of Involuntary Disenrollees (Booske et al., 2002), we compared results from the Kaiser Family Foundation study of beneficiaries affected by plan withdrawals in January 1999 with those affected by the January 2001 withdrawals and noted a lower percentage of beneficiaries reporting enrollment in another HMO (52 percent in 2001 compared to 77 percent in 1999), even though a similar proportion, four out of five, beneficiaries still had an HMO option available to them. However, CMS enrollments only confirmed enrollment in another Medicare HMO for 35 percent of the 2001 involuntary disenrollees. Consequently, for this report on the 2002 Survey of Involuntary Disenrollees, we reported enrollment in a Medicare HMO based on CMS records, not beneficiary reports. Based on CMS data, a very similar percentage (34 percent) of beneficiaries enrolled in another Medicare HMO when their plan withdrew in 2002 compared to 2001 (35 percent). As was true in 1999 and 2001, enrollment in another HMO was strongly related to the level of market penetration of Medicare HMOs in an area. Beneficiaries living in Region III (MD, VA, DC, DE, PA, and WV) were significantly more likely to enroll in another Medicare HMO than those in other regions of the country. This Region III characteristic may be due to an employer/union effect. The states in this region have relatively high proportions of employer-sponsored M+C coverage. (In this sample, 29 percent of respondents reported having coverage

through their employer compared to 14 percent of respondents in the other regions.) Employers/unions may have facilitated enrollment in another HMO (whether a Medicare-contracting one or not). After managed care's role in a local market, having enough information was the next most likely predictor of beneficiaries choosing to enroll in another HMO. As opposed to reverting to Original Medicare coverage, joining another HMO requires a conscious action on behalf of the beneficiary. Those who felt they did not have enough information may not have known that there was another HMO that they could join.

Just over half of beneficiaries affected by the plan withdrawals ended up paying higher premiums. However, average monthly premiums also increased for all M+C enrollees along with increases in co-payments and reductions in benefits. For the involuntary disenrollees, paying higher premiums was associated with having supplemental insurance or a PFFS plan, not with enrollment in another HMO. Consequently, those in the more vulnerable subgroups were less likely to report paying more since they were less likely to have supplemental coverage. This is consistent with our findings in 2001. It is likely that in the tradeoff between higher premiums and lower benefits, the vulnerable were forced by circumstance to go with lower benefits.

In 2001, we found that disruptions in provider arrangements were less widespread than other possible outcomes of the plan withdrawals. One in five beneficiaries reported having to change providers, and one out of ten beneficiaries had to stop seeing a specialist in 2001. These rates were even lower in 2002: only 16 percent reported having to change providers and 1 in 20 had to stop seeing a specialist. However, those in areas with a choice of another HMO were more likely to report having to change their personal doctor or nurse than those without another HMO option. Disabled beneficiaries were twice as likely to have to stop seeing a specialist as aged beneficiaries. As would be expected, the potential for disruption in provider arrangements was a tradeoff that beneficiaries had to deal with in exchange for HMO coverage and the potential for more comprehensive benefits. Those who did not enroll in a different HMO were less likely to have to change providers. Beneficiaries with coverage through an employer or other supplemental insurance were less likely to have to stop seeing a specialist. While the differences were not large, beneficiaries reported less impact in terms of access to care for the 2002 plan withdrawals than for those in the previous year. However, the impact was still greatest for the more vulnerable.

Overall, the incidence of potentially negative impacts of plan withdrawals, such as disruption in provider arrangements and reduced access to care, appears to have affected relatively fewer beneficiaries in 2002 than in 2001. However, those in vulnerable subgroups such as the disabled, those in poor health, and those with less education, continued to be more likely to experience negative consequences than other beneficiaries. Furthermore, there was no observed improvement in the level of awareness of options or understanding of what would happen when a plan stopped covering its beneficiaries.

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Appendix A: Data Collection Activities

DATA COLLECTION ACTIVITIES

The 2002 Survey of Medicare Beneficiaries Who Involuntarily Disenroll From Their Health Plans was conducted as a mail survey with telephone follow-up with mail survey non-respondents. The mail survey consisted of the following:

- A pre-notification letter was sent to all sample members. This letter described the sponsorship and purpose of the survey, contained informed consent statements, and alerted sample members that they would receive the survey questionnaire in about a week.

- An initial questionnaire package, which contained a cover letter, the questionnaire, and a pre-addressed, postage-paid return envelope, was sent to all sample members approximately 12 days after the pre-notification letter was mailed. This package included a help sheet listing all of the "product names" by which the sample health plan could be known, and a brochure that contained Frequently Asked Questions and answers to those questions. A Spanish request postcard was also included for sample members who wished to receive a copy of the questionnaire in Spanish.

- A thank you/reminder postcard, which was sent to all sample members 7 days after the initial questionnaire package was mailed. The purpose of this card was to thank sample members who had already completed and returned the questionnaire, and to remind sample members who had not to do so at their earliest convenience.

- A second questionnaire package was sent to all sample members who **did not return** a completed questionnaire to RTI within 4 weeks of the initial questionnaire mailing. The second questionnaire was accompanied by a cover letter that contained a stronger appeal for the sample member's help with the survey, and it also contained a pre-addressed, postage-paid envelope.

- A third questionnaire, which was mailed to all sample members who had not returned a completed questionnaire to RTI within 3 weeks after the *second* questionnaire package was mailed and for whom a telephone number could not be obtained. The third questionnaire package was sent by Federal Express and contained a cover letter making a special appeal to sample members, as well as a pre-addressed, postage-paid envelope.

Sample members were given the option in the pre-notification letter to request a telephone interview or to complete and return the mail survey questionnaire. Telephone interviews were also conducted as a follow-up for non-respondents to the mail survey. Since CMS was not able to provide telephone numbers for Medicare beneficiaries, it was necessary to conduct tracing activities prior to starting the telephone follow-up of non-respondents. We used a combination of three sources to obtain a current telephone number for the sample members, including a commercial telephone number look-up service, calls to directory assistance, and various electronic databases. RTI's in-house Tracing Operations Unit conducted more extensive tracing for a telephone number for a sample member if one was not provided by a commercial telephone number look-up service. The questionnaires used in the telephone follow-up interviews mirrored the mail survey questionnaires as closely as possible. Interviews were conducted using a computer-assisted telephone interviewing (CATI) program. An extensive quality control program was conducted on all data collection and processing activities to ensure the quality of the data collected.

Appendix B: Non-Response Analysis

NON-RESPONSE ANALYSIS

Analyzing raw survey data can lead to misleading conclusions when adjustments for non-response are not taken into account. One of the common problems with raw, unweighted statistics is that it assumes that the responses of non-respondents (had they been obtained) occur proportionally across all subgroups. If this assumption is violated and if the responses of the affected subgroup are different than another (e.g., males respond differently than females), then differential non-response can occur.

One method for addressing differential non-response bias is to use logistic regression to model the functional relationship between a set of predictors and a dichotomous response outcome and then use that model to construct response propensity weights (Folsom, 1991: see reference section of report). If the relationship is significant, the model-based adjustment factors that are applied to the sampling weights greatly reduce the potential for non-response bias attributable to the response predictors.

Although response propensity modeling provides a formal statistical methodology for exploring factors related to a response, one should be careful when interpreting the results from these models. To construct such models, data are needed for respondents and non-respondents. When data on the non-respondents are limited, it is possible that some predictor variables are confounded or intercorrelated with other factors that are not in the model. The predictor variable then can achieve statistical significance by acting as a surrogate. For instance, in the Medicare population, a person's age could conceivably be a surrogate for their health status.

The response propensity model used in this survey was defined as:

$$Y_i = \begin{cases} 1, & \text{if a beneficiary completes a survey} \\ 0, & \text{otherwise} \end{cases}$$

Then we developed and used the following logistic model to estimate the probability that the beneficiary responded,

$$\begin{aligned} \hat{g}_i = \; & P[Y_i = 1 \mid X_i, \hat{b}] \\ & = [1 + \exp(-X_i \hat{b})]^{-1} \end{aligned}$$

where Xi is a vector of predictor variables.

This model-based approach allowed us to jointly examine the relationship between obtaining a response and another set of predictor variables. As mentioned above, when conducting non-response analysis, the key is to have predictor data on the respondents and non-respondents. For this project, we had several variables available on Medicare beneficiaries in each of the four strata—age, race, sex, census region, indicator variables based on address fields, hospice, and dually eligible data.

Four indicator variables were created by searching address fields for certain keywords—rural routes, P.O. boxes, apartments, and gatekeeper addresses. The latter category usually indicates a mailing that goes through a third party before reaching its intended recipient. For example, John Doe in care of Jane Doe. A fifth indicator variable was created for atypical addresses. For example,

two-line addresses that contained just a name, city, and state could very well have lower response rates.

The initial model contained all main effects along with two-way interactions. A backwards stepwise approach was used to remove the least significant variables one at a time if they had p-values greater than 0.20; however, design variables were always retained in the model regardless of their p-value. The final model contained nine variables—stratum, age, race, sex, dual eligibility, census region, P.O. box, rural route, and gatekeeper. These variables, along with their degrees of freedom, odds ratios, and the p-values from the Wald F statistic for significance, are shown in Table B.1.

Within the "group" design variable, "Orphans" as a whole generally had a higher response than "Non-orphans." The age of the sample member was also an important predictor for obtaining a response. As in previous studies, we saw the odds of a response decrease among the elderly (75-84 years of age) and very elderly (over 85 years of age). Also, sample members 44 years of age or younger (the disabled) had a lower odds of response. Caucasians had a much higher response than either African-Americans or other minority populations, but no statistically significant differences were observed between males and females. Sample members that were dually eligible for both Medicare and Medicaid also had a lower response rate.

Although response rates varied among the nine U.S. census regions, they were not statistically different as a whole. This variable, along with the indicators for P.O. boxes and gate keepers, were still retained in the non-response model even though they had p-values greater than 0.05 because they contributed to the overall fit. The indicator for rural routes, however, was very significant (<.01). Sample members with these addresses were much less likely to respond to the survey than sample members with other types of addresses.

Table B.1
Variables included within response propensity model with degrees of freedom, odds ratios, and p-values from Wald F statistic for significance.

Variable	Degrees of freedom	Odds ratio	P-value of Wald F
Group (design variable)	3		0.0060
Orphans, 65+ to Non-Orphans, 65+		1.37	
Non-Orphans, 64- to Non-Orphans, 65+		0.71	
Orphans, 64- to Non-Orphans, 65+		1.21	
Age categories	4		0.0471
(0 – 44) to (65–74)		0.68	
(45-64) to (65-74)		1.00	
(75-84) to (65-74)		0.84	
(85+) to (65-74)		0.69	
Race	2		0.0389
Caucasian to African-American		1.45	
Other minorities to African-American		1.00	
Sex	1		0.1438
Males to Females		0.86	
Dual eligibility	1	0.68	0.0888
U.S. Census divisions	8		0.0977
New England to South Atlantic		0.60	
Middle Atlantic to South Atlantic		0.77	
East North Central to South Atlantic		0.94	
West North Central to South Atlantic		0.95	
East South Central to South Atlantic		0.66	
West South Central to South Atlantic		0.59	
Mountain to South Atlantic		0.62	
Pacific to South Atlantic		0.71	
Rural routes	1	0.34	0.0022
P.O. box	1	0.63	0.0504
Gatekeeper	1	0.58	0.0686

Appendix C: Tables of Results

Table C.1
Sample strata by beneficiary characteristics: 2001 and 2002

Beneficiary characteristic	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Age						
Under 65 years	-	-	96.5	96.4	6.4	7.0
65-74 years	50.6	59.3	3.5	3.6	48.8	52.7
75-84 years	38.8	33.0	-	-	35.3	33.0
85 years or more	10.6	7.7	-	-	9.5	7.3
Gender						
Male	41.9	43.5	49.9	53.3	42.7	43.1
Female	58.1	56.5	50.1	46.7	57.3	56.9
Race/Ethnicity						
White non-Hispanic	86.7	90.8	75.4	82.1	86.6	84.1
African-American	6.6	4.5	14.1	8.0	6.7	9.4
Hispanic	4.0	2.6	7.2	5.8	4.0	4.5
Other	2.7	2.0	3.4	4.1	2.7	2.0
Education						
Less than 9th grade	11.5	13.0	9.9	11.5	11.6	12.9
Some high school	18.8	18.3	13.6	14.9	18.4	17.5
High school graduate	38.4	39.2	33.7	40.9	38.3	36.4
Beyond high school	31.4	29.5	42.8	32.7	31.7	33.1
Self-reported health status						
Excellent	5.3	6.4	.9	1.4	5.2	5.6
Very good	24.4	20.8	10.2	5.2	22.9	21.7
Good	40.9	38.0	24.8	20.2	39.3	37.2
Fair	25.0	27.9	42.5	44.2	26.6	27.7
Poor	4.4	6.9	21.6	29.0	6.0	7.8
Patient in hospital overnight or longer						
Yes	21.3	19.8	27.0	30.3	21.5	21.0
No or missing	78.7	80.2	73.0	69.7	78.5	79.0
Location						
Metropolitan county	99.3	82.8	98.6	79.0	96.5	91.7
Non-metropolitan county	.7	17.2	1.4	21.0	3.5	8.3
Dual eligibility status						
Medicaid eligible	2.0	4.1	11.9	9.8	2.9	3.3
Not Medicaid eligible	98.0	95.9	88.1	90.2	97.1	96.7

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.
Metropolitan/non-metropolitan county designation based on Office of Management and Budget (OMB) 1993 definition.
SOURCE: Survey of Involuntary Disenrollees 2002, 2001 CMS Enrollment Data Base.
Indicates chi-square significant at .01 level

Table C.2
Sample strata by beneficiary reports of information about plan withdrawals and new coverage: 2001 and 2002

Information about plan withdrawals	2002 Aged: Medicare HMO Available	2002 Aged: No Medicare HMO Available	2002 Disabled: Medicare HMO Available	2002 Disabled: No Medicare HMO Available	2002 Total	2001 Total
Unweighted base	n=1556	n=1609	n=385	n=437	n=3987	
			Percent			
First found out that plan would stop coverage						
From plan itself	65.5	65.6	62.7	62.2	65.4	65.6
From newspaper, radio or TV	18.0	17.5	12.1	13.9	17.6	18.4
From doctor or other provider	5.7	5.1	9.3	8.4	5.8	5.6
From friend or relative	4.2	6.6	7.1	9.6	4.8	4.2
From current or former employer	1.3	.7	0.7	0.2	1.2	1.3
From Medicare program	1.6	1.0	4.3	3.1	1.7	1.5
From other sources	0.3	.3	0.8	0.2	.3	0.4
From multiple sources	0.6	.4	0.7	0.9	.6	
Don't know, missing or unable to code	2.7	2.8	2.2	1.4	2.6	3.0
Received letter from plan						
Yes	94.4	94.2	91.3	93.2	94.2	95.5
No	3.4	2.7	5.6	4.7	3.5	2.3
Don't know or missing	2.1	3.1	3.0	2.1	2.3	1.4
Who makes decisions about health insurance						
Beneficiary alone	49.3	48.8	60.7	54.9	49.9	55.1
Beneficiary with someone else	43.5	45.0	32.3	39.9	43.1	39.1
Someone else makes decision	5.0	3.6	5.7	3.9	4.9	4.7
Don't know or missing	2.1	2.6	1.3	1.4	2.1	1.0

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.3
First source of information about plan withdrawal by beneficiary characteristics: 2002

Beneficiary characteristic	First source of information: Non-renewing plan	TV, radio, or newspaper	Doctor or other provider	Friend or relative	All other sources[1]
Unweighted base	n=2,590	n=675	n=241	n=239	n=242
			Percent		
All beneficiaries 2002	65.4	17.6	5.8	4.8	6.4
(2001)	(65.6)	(18.4)	(5.6)	(4.2)	(6.2)
Age					
Under 65 years	62.7	12.2	9.2	7.5	8.3
65-74 years	63.3	20.5	5.4	4.9	5.8
75-84 years	67.0	17.1	5.3	4.3	6.3
85 years or over	71.2	7.9	7.6	4.6	8.6
Gender					
Male	65.9	17.1	5.4	4.7	7.1
Female	65.0	18.0	6.2	4.9	5.9
Race/ethnicity					
White non-Hispanic	65.3	18.7	5.5	4.7	5.8
All other racial groups and Hispanic	65.6	10.6	7.8	5.6	10.4
Education					
Less than 9th grade	70.3	10.2	8.0	4.7	6.8
Some high school	72.1	12.6	4.1	5.2	6.0
High school graduate	65.7	18.2	5.0	5.0	6.1
More than high school	60.1	21.9	7.3	4.6	6.2
Self-reported health status					
Poor or fair	66.0	14.8	7.0	5.2	7.0
Good to excellent	65.5	18.9	5.2	4.6	5.8
Patient in hospital overnight or longer					
Yes	66.3	14.8	7.6	5.5	5.9
No or missing	65.1	18.4	5.4	4.6	6.5
Location					
Metropolitan county	65.3	17.8	5.8	4.6	6.4
Non-metropolitan county	66.1	11.9	6.2	10.1	5.7
Dual eligibility status					
Not Medicaid eligible	65.3	17.9	5.8	4.9	6.2
Medicaid eligible	68.3	7.0	6.9	3.3	14.5

[1] Includes those who did not answer the question and those who did not know their first source of information.

NOTES: Percentages are based on weighted data. Rows may not sum to 100 due to rounding.
SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.4
Sample strata by beneficiary understanding of available options: 2001 and 2002

Beneficiary characteristic	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	
			Percent			
Another Medicare HMO available						
Yes	55.6	18.8	52.8	14.0	49.4	46.2
No	13.7	40.3	13.8	47.3	18.1	25.1
Don't know or missing	30.7	40.9	33.5	38.7	32.5	28.7
Supplemental insurance plan available						
Yes	70.3	76.0	50.8	56.9	70.0	68.1
No	7.4	8.3	17.2	20.6	8.3	11.4
Don't know or missing	22.2	15.7	31.9	22.5	21.8	20.5
What did they think would happen when the plan stopped covering them						
Covered by original Medicare	42.2	45.6	45.4	53.5	43.0	48.0
Able to select a new plan	3.4	3.7	1.5	0.9	3.3	2.4
Obtain coverage through employer	3.2	3.1	0.8	0.5	3.1	1.9
Have to purchase supplemental insurance	0.6	0.9	0.3	0.2	.7	.5
End up with no health insurance	33.0	30.9	32.3	28.5	32.6	28.0
Automatically enrolled in another HMO	6.4	4.2	8.0	7.9	6.1	7.3
Still stay in same insurance plan	2.6	1.8	3.1	1.9	2.5	1.8
Don't know, missing, or unable to code	8.6	9.8	8.6	6.6	8.7	10.2

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.5
Logistic regression of knowing whether another Medicare HMO available (for those in areas with and without choice of another Medicare HMO)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.66	0.22	2.01
Age			
Under 65 years	0.85	0.66	1.10
65-74 years	1.00	1.00	1.00
75-84 years	0.83	0.67	1.02
85 years or more	0.91	0.64	1.31
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.88	0.59	1.30
Hispanic	0.62	0.36	1.07
Other	0.65	0.36	1.17
Gender			
Male	1.00	1.00	1.00
Female	0.95	0.79	1.15
Education			
Less than 9th grade	0.93	0.67	1.28
Some high school	0.79	0.60	1.03
High school graduate	1.00	1.00	1.00
Beyond high school	1.13	0.91	1.42
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.04	0.66	1.63
Good	0.89	0.57	1.37
Fair	0.82	0.52	1.30
Poor	0.79	0.45	1.39
Patient in hospital overnight or longer			
Yes	0.93	0.73	1.17
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.15	0.73	1.82
Beneficiary with someone else	1.38	0.88	2.17
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	0.97	0.72	1.30
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.42 *	1.17	1.73
No	1.00	1.00	1.00

Table C.5 (continued)

Independent variable	Odds Ratio	95% Confidence Interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	2.02 *	1.48	2.77
No	1.58 *	1.14	2.21
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.42 *	1.08	1.86
Family or friend	1.25	0.84	1.87
TV, radio, or newspaper	1.35	0.89	2.03
Other	1.07	0.70	1.63
Received letter from plan			
Yes	1.66 *	1.04	2.63
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	2.49 *	1.29	4.81
Moderate (15-34%)	1.11	0.66	1.84
Limited (6-14%)	1.06	0.65	1.72
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.47 *	0.28	0.79
$525	1.00	1.00	1.00
$525-600	1.44 *	1.11	1.87
> $600	2.01 *	1.47	2.74
CMS region			
Region I: Boston	0.74	0.46	1.18
Region II: New York	0.96	0.61	1.50
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	1.05	0.67	1.63
Region V: Chicago	0.66	0.42	1.02
Region VI: Dallas	0.83	0.54	1.29
Region IX: San Francisco	1.17	0.71	1.94
Regions VII, VIII, X: Kansas City, Denver, Seattle	0.60 *	0.38	0.96

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.094.
Sample size for model = 3,961.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.6
Reports of availability of supplemental insurance and understanding of implications of plan withdrawal by beneficiary characteristics

Beneficiary characteristic	Beneficiaries reporting that supplemental insurance available	Beneficiaries who understood what would happen when their plan withdrew[1]
Unweighted base	n=3987	n=3987
	Percent	
All beneficiaries 2002	70.0	50.0
(2001)	(68.1)	(52.8)
Age		
Under 65 years	51.0	49.8
65-74 years	74.5	50.4
75-84 years	67.8	50.2
85 years or over	67.5	47.1
Gender		
Male	70.6	52.9
Female	69.5	47.8
Race/ethnicity		
White non-Hispanic	73.0	52.0
All other racial groups and Hispanic	50.5	36.9
Education		
Less than 9th grade	63.2	40.0
Some high school	66.6	45.0
High school graduate	71.9	49.2
Beyond high school	74.9	59.7
Self-reported health status		
Excellent	72.3	53.3
Very good	73.4	55.1
Good	71.9	48.6
Fair	68.5	48.9
Poor	53.9	42.5
Information about plan withdrawal		
Received enough information	77.7	55.6
Did not receive enough information	57.9	41.3

[1] Percentage of beneficiaries who thought they would be covered by the Original Medicare plan, covered through their current or former employer, would be able to select a new plan, or would have to purchase supplemental insurance.

NOTE: Percentages are based on weighted data.

SOURCE: Survey of Involuntary Disenrollees 2002

Indicates chi-square significant at .01 level

Table C.7
Logistic regression of reporting that supplemental insurance available

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.57	0.16	2.03
Age			
Under 65 years	0.42 *	0.32	0.54
65-74 years	1.00	1.00	1.00
75-84 years	0.80	0.64	1.01
85 years or more	0.91	0.62	1.32
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.31 *	0.21	0.45
Hispanic	0.42 *	0.26	0.68
Other	0.85	0.44	1.64
Gender			
Male	1.00	1.00	1.00
Female	0.94	0.77	1.15
Education			
Less than 9th grade	0.75	0.54	1.05
Some high school	0.89	0.67	1.17
High school graduate	1.00	1.00	1.00
Beyond high school	1.21	0.95	1.55
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.02	0.62	1.66
Good	1.00	0.62	1.60
Fair	1.01	0.62	1.65
Poor	0.52 *	0.29	0.94
Patient in hospital overnight or longer			
Yes	1.00	0.79	1.28
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.09	0.67	1.76
Beneficiary with someone else	1.29	0.80	2.08
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.05	0.76	1.44
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.30 *	1.05	1.60
No	1.00	1.00	1.00

Table C.7 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.54 *	1.11	2.12
No	1.74 *	1.23	2.45
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.49 *	1.11	1.99
Family or friend	1.57 *	1.01	2.44
TV, radio or newspaper	0.66 *	0.44	0.99
Other	1.04	0.68	1.59
Received letter from plan			
Yes	2.31 *	1.50	3.55
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.75	0.37	1.54
Moderate (15-34%)	1.23	0.69	2.16
Limited (6-14%)	1.17	0.68	2.02
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	1.01	0.48	2.13
$525	1.00	1.00	1.00
$525-600	0.81	0.61	1.08
> $600	0.82	0.59	1.13
CMS region			
Region I: Boston	1.44	0.89	2.33
Region II: New York	1.15	0.74	1.79
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	1.42	0.91	2.22
Region V: Chicago	1.13	0.72	1.78
Region VI: Dallas	1.40	0.87	2.24
Region IX: San Francisco	1.78 *	1.08	2.95
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.82 *	1.08	3.06

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.082.
Sample size for model = 3,961.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.8
Logistic regression of understanding the implications of plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.16	0.05	0.46
Age			
Under 65 years	1.05	0.83	1.34
65-74 years	1.00	1.00	1.00
75-84 years	1.07	0.87	1.31
85 years or more	1.13	0.80	1.60
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.53 *	0.36	0.78
Hispanic	0.65	0.41	1.04
Other	0.49 *	0.27	0.88
Gender			
Male	1.00	1.00	1.00
Female	0.82 *	0.69	0.98
Education			
Less than 9th grade	0.69 *	0.50	0.95
Some high school	0.88	0.68	1.13
High school graduate	1.00	1.00	1.00
Beyond high school	1.59 *	1.28	1.96
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.16	0.77	1.75
Good	0.97	0.65	1.44
Fair	1.07	0.70	1.62
Poor	0.85	0.51	1.43
Patient in hospital overnight or longer			
Yes	0.70 *	0.56	0.88
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.08	0.70	1.68
Beneficiary with someone else	1.15	0.74	1.77
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.02	0.78	1.34
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.25 *	1.04	1.50
No	1.00	1.00	1.00

Table C.8 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.30	0.96	1.77
No	1.13	0.81	1.57
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.08	0.85	1.37
Family or friend	0.79	0.54	1.14
TV, radio or newspaper	0.48 *	0.32	0.74
Other	1.01	0.69	1.49
Received letter from plan			
Yes	2.43 *	1.57	3.76
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.88	0.46	1.68
Moderate (15-34%)	0.86	0.51	1.47
Limited (6-14%)	1.04	0.62	1.73
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2002)			
< $525	0.97	0.57	1.65
$525	1.00	1.00	1.00
$525-600	0.93	0.72	1.21
> $600	0.86	0.64	1.15
CMS region			
Region I: Boston	1.90 *	1.23	2.92
Region II: New York	1.87 *	1.26	2.80
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	2.11 *	1.40	3.17
Region V: Chicago	1.40	0.92	2.12
Region VI: Dallas	2.20 *	1.45	3.32
Region IX: San Francisco	1.69 *	1.08	2.64
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.30	0.83	2.04

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.072.
Sample size for model = 3,961.

SOURCE:` Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.9
Sample strata by beneficiaries' reports about concerns about plan withdrawals: 2001 and 2002

	2002					
	Aged		Disabled			
Beneficiary concern	**Medicare HMO available**	**No Medicare HMO available**	**Medicare HMO available**	**No Medicare HMO available**	**2002 Total**	**2001 Total**
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	
			Percent			
Concern about having to change personal doctor or nurse						
Not at all concerned	19.7	31.2	14.1	22.2	21.2	20.9
A little concerned	13.6	15.8	9.4	13.9	13.7	12.2
Somewhat concerned	18.1	17.8	10.0	14.7	17.6	15.2
Very concerned	44.8	30.9	63.2	45.6	43.7	47.3
Don't know or missing	2.3	2.2	1.3	1.6	2.2	1.7
Do not have personal doctor or nurse	1.5	2.1	2.0	2.1	1.6	2.7
Concern about no longer being able to pay for health care						
Not at all concerned	11.5	12.3	5.9	4.5	11.2	11.3
A little concerned	16.3	16.9	9.2	7.2	15.9	14.5
Somewhat concerned	20.7	20.2	18.2	12.9	20.3	21.2
Very concerned	48.5	47.5	65.6	74.5	49.6	50.3
Don't know or missing	3.0	3.2	1.0	0.9	2.9	2.6
Concern about not being able to get health care needed						
Not at all concerned	13.3	16.9	6.2	4.8	13.3	13.3
A little concerned	15.3	16.7	9.3	8.4	15.1	15.4
Somewhat concerned	20.7	19.8	13.5	15.6	20.1	19.4
Very concerned	48.2	43.8	69.6	70.6	49.0	49.7
Don't know or missing	2.6	2.7	1.5	0.7	2.5	2.3

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.10
Concerns about plan withdrawals by beneficiary characteristics: 2002

Beneficiary characteristic	Beneficiaries very concerned about having to change providers	Beneficiaries very concerned about paying for care	Beneficiaries very concerned about getting care
Unweighted base	n=3987	n=3987	n=3987
		Percent	
All Beneficiaries 2002	43.7	49.6	49.0
(2001)	(49.5)	(51.7)	(50.9)
Age Group			
Under 65 years	59.3	67.9	70.2
65-74 years	44.5	50.4	49.7
75-84 years	41.3	46.2	45.0
85 years or over	38.4	46.2	45.7
Gender			
Male	42.1	46.3	46.1
Female	44.9	52.1	51.1
Race/Ethnicity			
White non-Hispanic	41.8	48.3	46.8
All other racial groups and Hispanic	56.0	58.4	62.9
Education			
Less than 9th grade	55.9	61.3	62.4
Some high school	45.5	54.1	48.6
High school graduate	42.2	49.6	49.5
Beyond high school	40.6	43.2	43.3
Self-reported Health			
Poor to fair	50.6	57.7	59.1
Good to excellent	40.4	45.7	44.0
Hospitalized in past 12 months			
Yes	46.2	53.1	53.6
No or missing	43.0	48.7	47.7
Location			
Metropolitan county	44.1	49.5	48.9
Non-metropolitan county	34.4	53.2	49.9
New coverage arrangements			
Medicare HMO	51.0	49.3	50.8
Covered under Medicaid	44.1	62.1	64.2
Employer-provided	36.6	33.0	32.3
Supplemental	38.5	46.1	45.7
Original Medicare only	44.0	65.1	58.6

NOTE: Percentages are based on weighted data.

SOURCES: Survey of Involuntary Disenrollees 2002, 2001 CMS files

Indicates chi-square significant at .01 level

Table C.11
Logistic regression of being very concerned about getting and paying for care after plan withdrawal

Independent variable	Odds ratio		95% Confidence interval Lower limit	Upper limit
Intercept	0.14	*	0.04	0.48
Age				
Under 65 years	1.51	*	1.16	1.96
65-74 years	1.00		1.00	1.00
75-84 years	0.81		0.64	1.02
85 years or more	0.65	*	0.43	0.98
Race/ethnicity				
White non-Hispanic	1.00		1.00	1.00
African-American	1.35		0.92	2.00
Hispanic	1.15		0.67	1.99
Other	1.03		0.54	1.95
Gender				
Male	1.00		1.00	1.00
Female	1.18		0.96	1.44
Education				
Less than 9th grade	1.56	*	1.11	2.19
Some high school	0.97		0.73	1.28
High school graduate	1.00		1.00	1.00
Beyond high school	0.95		0.74	1.21
Self-reported health				
Excellent	1.00		1.00	1.00
Very good	1.19		0.67	2.13
Good	1.77	*	1.01	3.10
Fair	2.05	*	1.15	3.65
Poor	3.08	*	1.61	5.87
Patient in hospital overnight or longer				
Yes	0.95		0.75	1.22
No or missing	1.00		1.00	1.00
Who makes health insurance decisions				
Beneficiary alone	1.25		0.76	2.06
Beneficiary with someone else	1.14		0.70	1.87
Someone else	1.00		1.00	1.00
Help completing survey				
Yes	1.37	*	1.01	1.85
No or missing	1.00		1.00	1.00
Seeing a specialist				
Yes	1.27	*	1.03	1.57
No	1.00		1.00	1.00
Former plan paid cost of medicines				
Yes	1.23		0.87	1.73
No	1.30		0.91	1.88
Don't know or missing	1.00		1.00	1.00

Table C.11 (continued)

Independent variable	Odds Ratio	95% Confidence Interval Lower limit	Upper limit
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.08	0.82	1.42
Family or friend	1.31	0.87	1.98
TV, radio or newspaper	1.22	0.80	1.88
Other	1.20	0.79	1.83
Received letter from plan			
Yes	1.34	0.83	2.16
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.73	0.35	1.51
Moderate (15-34%)	0.90	0.49	1.65
Limited (6-14%)	0.83	0.47	1.48
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.71	0.40	1.27
$525	1.00	1.00	1.00
$525-600	1.05	0.78	1.41
> $600	1.53 *	1.09	2.14
CMS region			
Region I: Boston	1.29	0.78	2.13
Region II: New York	1.44	0.90	2.30
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	1.46	0.91	2.34
Region V: Chicago	1.10	0.67	1.78
Region VI: Dallas	1.54	0.96	2.48
Region IX: San Francisco	1.64	0.99	2.72
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.16	0.70	1.91
Supplemental insurance			
Reports it is available	0.69	0.55	0.86
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.17	0.93	1.45
Does not know if Medicare HMO available	1.00	1.00	1.00
Understanding of plan withdrawal			
Understood what would happen	0.47	0.39	0.58
Did not understand what would happen	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.085.
Sample size for model = 3,961.

SOURCE: Survey of Involuntary Disenrollees 2002.

* Odds ratios are significant at 95% probability level.

Table C.12
Sample strata by beneficiary reports about choosing new coverage: 2001 and 2002

Beneficiary characteristic	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	
			Percent			
Satisfaction with time to choose new insurance						
Not at all satisfied	18.6	12.9	31.1	33.5	18.6	15.0
Not very satisfied	18.2	16.1	23.3	16.7	18.1	16.7
Somewhat satisfied	38.3	35.1	29.2	31.3	37.2	36.9
Very satisfied	20.5	28.9	13.2	13.1	21.2	26.0
Extremely satisfied	1.9	3.7	1.0	2.3	2.1	3.1
Don't know or missing	2.6	3.3	2.2	3.1	2.7	2.4
Received enough information about options						
Yes	61.5	65.3	46.3	45.6	61.1	62.6
No	35.0	30.4	51.1	52.6	35.4	34.5
Don't know or missing	3.5	4.3	2.6	1.8	3.6	2.9

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.
SOURCE: Survey of Involuntary Disenrollees 2002, 2001
Indicates chi-square significant at .01 level

Table C.13
Logistic regression of having enough information about coverage options

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.20 *	0.07	0.58
Age			
Under 65 years	0.72 *	0.56	0.92
65-74 years	1.00	1.00	1.00
75-84 years	1.27 *	1.03	1.58
85 years or more	0.85	0.60	1.21
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.93	0.63	1.38
Hispanic	1.44	0.86	2.40
Other	1.05	0.57	1.94
Gender			
Male	1.00	1.00	1.00
Female	0.87	0.72	1.04
Education			
Less than 9th grade	1.21	0.87	1.67
Some high school	1.07	0.82	1.39
High school graduate	1.00	1.00	1.00
Beyond high school	0.80	0.64	1.01
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.43	0.90	2.28
Good	1.43	0.91	2.26
Fair	1.31	0.82	2.10
Poor	1.10	0.63	1.92
Patient in hospital overnight or longer			
Yes	0.98	0.78	1.23
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.58 *	1.01	2.46
Beneficiary with someone else	1.71 *	1.10	2.66
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	0.81	0.60	1.08
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.03	0.84	1.25
No	1.00	1.00	1.00

Table C.13 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.54	1.13	2.10
No	1.41	1.01	1.95
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	0.76 *	0.58	0.98
Family or friend	0.75	0.52	1.09
TV, radio or newspaper	0.71	0.46	1.09
Other	0.88	0.59	1.31
Received letter from plan			
Yes	2.30 *	1.48	3.57
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	1.64	0.88	3.04
Moderate (15-34%)	1.28	0.79	20.80
Limited (6-14%)	1.38	0.86	2.21
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	1.02	0.61	1.69
$525	1.00	1.00	1.00
$525-600	0.87	0.66	1.14
> $600	1.05	0.76	1.43
CMS region			
Region I: Boston	1.27	0.80	2.02
Region II: New York	0.72	0.48	1.10
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	0.93	0.62	1.42
Region V: Chicago	0.91	0.59	1.14
Region VI: Dallas	0.87	0.56	1.34
Region IX: San Francisco	0.75	0.47	1.19
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.45	0.90	2.36
Supplemental insurance			
Reports it is available	2.05 *	1.66	2.52
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	0.93	0.76	1.13
Does not know if Medicare HMO available	1.00	1.00	1.00
Understanding of plan withdrawal			
Understood what would happen	1.42 *	1.17	1.72
Did not understand what would happen	1.00	1.00	1.00

Table C.13 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Level of concern about what would happen			
Very concerned	0.51 *	0.41	0.62
Not very concerned	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.102.
Sample size for model = 3,691.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.14
Logistic regression of being satisfied with the amount of time to choose new coverage

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.44	0.14	1.35
Age			
Under 65 years	0.64 *	0.50	0.82
65-74 years	1.00	1.00	1.00
75-84 years	1.01	0.82	1.25
85 years or more	0.93	0.64	1.34
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.89	0.59	1.32
Hispanic	0.82	0.49	1.38
Other	0.82	0.45	1.50
Gender			
Male	1.00	1.00	1.00
Female	1.00	0.83	1.21
Education			
Less than 9th grade	0.80	0.58	1.12
Some high school	1.11	0.85	1.46
High school graduate	1.00	1.00	1.00
Beyond high school	0.92	0.73	1.16
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.35	0.86	2.12
Good	1.20	0.78	1.86
Fair	0.99	0.63	1.56
Poor	0.73	0.42	1.28
Patient in hospital overnight or longer			
Yes	1.23	0.97	1.56
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.29	0.80	2.08
Beneficiary with someone else	1.28	0.80	2.06
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.34	0.99	1.80
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	0.94	0.77	1.14
No	1.00	1.00	1.00

Table C.14 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	0.97	0.70	1.33
No	0.87	0.62	1.23
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	0.67 *	0.52	0.87
Family or friend	0.46 *	0.31	0.68
TV, radio or newspaper	0.57 *	0.37	0.88
Other	0.77	0.52	1.15
Received letter from plan			
Yes	1.28	0.82	1.98
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	2.15 *	1.09	4.25
Moderate (15-34%)	1.52	0.87	2.65
Limited (6-14%)	1.70 *	1.00	2.88
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	1.72	0.97	3.07
$525	1.00	1.00	1.00
$525-600	0.78	0.59	1.02
> $600	0.65 *	0.48	0.89
CMS region			
Region I: Boston	1.59	0.99	2.25
Region II: New York	0.88	0.58	1.35
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	1.40	0.91	2.13
Region V: Chicago	1.04	0.67	1.61
Region VI: Dallas	0.93	0.60	1.44
Region IX: San Francisco	0.92	0.58	1.48
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.69 *	1.03	2.77
Supplemental insurance			
Reports it is available	2.11 *	1.70	2.61
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	0.83	0.68	1.02
Does not know if Medicare HMO available	1.00	1.00	1.00
Understanding of plan withdrawal			
Understood what would happen	1.20	0.99	1.46
Did not understand what would happen	1.00	1.00	1.00

Table C.14 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Level of concern about what would happen			
Very concerned	0.47 *	0.38	0.58
Not very concerned	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.11.
Sample size for model = 3,638.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.15
Sample strata by beneficiary reports of new coverage arrangements: 2001 and 2002

Beneficiary characteristic	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	
			Percent			
Enrolled in Medicare HMO per CMS	40.0	0.9	45.2	1.8	34.0	35.0
Enrolled in Medicare PFFS per CMS	0.2	3.0	0.3	7.5	0.7	0.9
Enrolled in Medicaid per respondent	4.4	7.0	8.1	9.9	5.0	5.1
Covered through employer per respondent	10.9	13.4	7.7	9.2	11.1	11.6
Respondent reports having supplemental insurance	30.7	55.8	15.7	29.2	33.6	29.8
No other coverage identified-Medicare only	13.8	19.9	23.1	42.4	15.6	17.6

NOTES: Percentages are based on weighted data. Columns may not sum to 100 due to rounding. Respondents could indicate coverage under more than one arrangement, so a hierarchical approach was used to assign them to the types of coverage. If CMS records showed enrollment in a Medicare HMO or a PFFS plan, they were assigned to one of these categories. For the remaining respondents (those without record of enrollment in an HMO), if they reported that Medicaid covered them, they were assigned to this category. This process was repeated for each category so that the final category represented all respondents with no record of enrollment in a Medicare HMO or PFFS plan and who were not covered by Medicaid, through a current or former employer, or through supplemental insurance. Thus, we designated these respondents as covered by Original Medicare only.

SOURCES: Survey of Involuntary Disenrollees 2002, 2001 CMS files

Indicates chi-square significant at .01 level

Table C.16
Logistic regression of beneficiaries in areas with choice of another HMO enrolling in a Medicare HMO per CMS records after plan withdrawal (excludes those with employer or Medicaid coverage)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.29	0.04	2.31
Age			
Under 65 years	2.06 *	1.39	3.07
65-74 years	1.00	1.00	1.00
75-84 years	1.12	0.84	1.49
85 years or more	0.88	0.53	1.48
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.90	0.53	1.55
Hispanic	1.17	0.57	2.38
Other	1.53	0.61	3.84
Gender			
Male	1.00	1.00	1.00
Female	1.09	0.83	1.42
Education			
Less than 9th grade	0.78	0.48	1.28
Some high school	0.88	0.61	1.28
High school graduate	1.00	1.00	1.00
Beyond high school	1.01	0.74	1.38
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	0.62	0.33	1.17
Good	0.88	0.48	1.61
Fair	0.73	0.38	1.40
Poor	0.55	0.24	1.29
Patient in hospital overnight or longer			
Yes	1.06	0.77	1.48
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.35	0.55	3.35
Beneficiary with someone else	1.16	0.47	2.84
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.10	0.70	1.74
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	0.85	0.64	1.12
No	1.00	1.00	1.00

Table C.16 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	0.92	0.56	1.51
No	1.06	0.61	1.83
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.06	0.73	1.53
Family or friend	1.46	0.89	2.39
TV, radio or newspaper	1.83 *	1.04	3.23
Other	0.82	0.38	1.76
Received letter from plan			
Yes	1.80	0.92	3.52
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	11.17 *	3.09	40.40
Moderate (15-34%)	4.52 *	1.39	14.64
Limited (6-14%)	4.10 *	1.23	13.67
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.90	0.22	3.80
$525	1.00	1.00	1.00
$525-600	1.18	0.76	1.82
> $600	1.03	0.64	1.64
CMS region			
Region I: Boston	0.05 *	0.03	0.10
Region II: New York	0.34 *	0.20	0.58
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	0.17 *	0.10	0.29
Region V: Chicago	0.12 *	0.06	0.22
Region VI: Dallas	0.32 *	0.16	0.67
Region IX: San Francisco	0.25 *	0.13	0.49
Regions VII, VIII, X: Kansas City, Denver, Seattle	0.67	0.29	1.50
Supplemental insurance			
Reports it is available	0.55 *	0.41	0.75
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	2.84 *	2.08	3.89
Does not know if Medicare HMO available	1.00	1.00	1.00
Understanding of plan withdrawal			
Understood what would happen	0.80	0.61	1.05
Did not understand what would happen	1.00	1.00	1.00

Table C.16 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Level of concern about what would happen			
Very concerned	1.36 *	1.02	1.83
Not very concerned	1.00	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	0.64 *	0.46	0.87
Satisfaction with time to choose			
Not at all satisfied	0.91	0.30	2.74
Not very satisfied	1.07	0.35	3.21
Somewhat satisfied	0.92	0.32	2.69
Very satisfied	0.97	0.32	2.87
Extremely satisfied	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.227.
Sample size for model = 1,522

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.17
Logistic regression of having other supplemental insurance after plan withdrawal (excludes those with employer or Medicaid coverage)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.18 *	0.04	0.86
Age			
Under 65 years	0.37 *	0.27	0.51
65-74 years	1.00	1.00	1.00
75-84 years	0.84	0.65	1.07
85 years or more	0.69	0.44	1.07
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.38 *	0.22	0.67
Hispanic	0.55	0.27	1.13
Other	0.77	0.33	1.76
Gender			
Male	1.00	1.00	1.00
Female	1.20	0.96	1.51
Education			
Less than 9th grade	0.81	0.55	1.20
Some high school	0.72 *	0.52	0.99
High school graduate	1.00	1.00	1.00
Beyond high school	1.24	0.95	1.64
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.09	0.64	1.87
Good	0.90	0.54	1.52
Fair	1.06	0.61	1.83
Poor	1.11	0.55	2.22
Patient in hospital overnight or longer			
Yes	1.05	0.79	1.40
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	0.84	0.40	1.74
Beneficiary with someone else	1.26	0.61	2.61
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.08	0.75	1.58
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.47 *	1.16	1.87
No	1.00	1.00	1.00

Table C.17 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.01	0.66	1.55
No	1.13	0.73	1.76
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.05	0.78	1.41
Family or friend	0.77	0.47	1.26
TV, radio or newspaper	0.54 *	0.34	0.86
Other	0.93	0.52	1.68
Received letter from plan			
Yes	1.28	0.73	2.24
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.29 *	0.13	0.65
Moderate (15-34%)	0.81	0.45	1.48
Limited (6-14%)	0.98	0.54	1.78
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.89	0.59	1.36
$525	1.00	1.00	1.00
$525-600	0.50 *	0.36	0.69
> $600	0.48 *	0.33	0.72
CMS region			
Region I: Boston	7.69 *	4.19	14.10
Region II: New York	2.76 *	1.59	4.80
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	3.66 *	2.09	6.42
Region V: Chicago	3.56 *	2.01	6.31
Region VI: Dallas	2.94 *	1.66	5.20
Region IX: San Francisco	3.19 *	1.64	6.21
Regions VII, VIII, X: Kansas City, Denver, Seattle	2.23 *	1.21	4.10
Supplemental insurance			
Reports it is available	4.25 *	3.19	5.64
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	0.74 *	0.57	0.94
Does not know if Medicare HMO available	1.00	1.00	1.00
Understanding of plan withdrawal			
Understood what would happen	0.82	0.65	1.03
Did not understand what would happen	1.00	1.00	1.00

Table C.17 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Level of concern about what would happen			
Very concerned	0.70 *	0.53	0.91
Not very concerned	1.00	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	1.39 *	1.06	1.83
Satisfaction with time to choose			
Not at all satisfied	0.59	0.27	1.33
Not very satisfied	0.97	0.45	2.13
Somewhat satisfied	1.07	0.50	2.28
Very satisfied	1.19	0.56	2.55
Extremely satisfied	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.222.
Sample size for model = 3,146.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.18
Sample strata by reasons cited by beneficiaries with Medicare only for not having supplemental insurance

Reason cited	Aged		Disabled		Total
	Medicare HMO available	No Medicare HMO available	Medicare HMO available	No Medicare HMO available	
Unweighted base[1]	n=461	n=344	n=175	n=221	n=1,201
			Percent		
Costs too much	61.9	66.1	54.3	70.6	62.0
Don't need it	20.0	13.3	9.5	4.5	18.0
Could not find policy with benefits needed	2.6	5.0	11.4	4.7	3.6
Applied and turned down/not accepted yet	2.6	2.6	9.3	7.0	3.2
Did not apply or thought they would be turned down	.9	1.2	6.1	4.0	1.4
Not available in area/not familiar with supplemental options	2.0	.3	3.4	3.1	2.0
Don't know, missing, or unable to code	10.0	11.6	6.0	6.1	9.7

[1] Includes only beneficiaries who indicated "No" to the question "Do you have supplemental health insurance now?"

NOTES: Percentages are based on weighted data. Columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002

Indicates chi-square significant at .01 level

Table C.19
Logistic regression of having only Original Medicare coverage after plan withdrawal (excludes those with employer or Medicaid coverage)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.33	0.04	2.37
Age			
Under 65 years	1.40	0.99	1.99
65-74 years	1.00	1.00	1.00
75-84 years	1.02	0.73	1.42
85 years or more	1.56	0.89	2.75
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	1.32	0.78	2.23
Hispanic	1.43	0.63	3.24
Other	0.60	0.23	1.61
Gender			
Male	1.00	1.00	1.00
Female	0.77	0.58	1.03
Education			
Less than 9th grade	1.11	0.68	1.80
Some high school	1.54 *	1.05	2.25
High school graduate	1.00	1.00	1.00
Beyond high school	0.75	0.53	1.07
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.12	0.61	2.08
Good	1.21	0.70	2.11
Fair	1.36	0.76	2.43
Poor	1.73	0.83	3.61
Patient in hospital overnight or longer			
Yes	0.82	0.57	1.19
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.58	0.65	3.82
Beneficiary with someone else	0.85	0.52	1.37
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	0.85	0.52	1.37
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	0.74	0.54	1.00
No	1.00	1.00	1.00

Table C.19 (continued)

Independent variable	Odds ratio		95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines				
Yes	1.07		0.66	1.72
No	0.89		0.55	1.45
Don't know or missing	1.00		1.00	1.00
First source of information				
Plan	1.00		1.00	1.00
Doctor or other provider	0.80		0.54	1.20
Family or friend	0.78		0.42	1.44
TV, radio or newspaper	1.02		0.53	1.95
Other	0.83		0.41	1.67
Received letter from plan				
Yes	0.46	*	0.25	0.86
No, don't know, or no response	1.00		1.00	1.00
Medicare managed care market penetration (12/2001)				
High (35%)	0.31	*	0.11	0.85
Moderate (15-34%)	0.58		0.28	1.20
Limited (6-14%)	0.69		0.33	1.44
Minimal (< 6%)	1.00		1.00	1.00
Medicare payment rate to MCOs (2001)				
< $525	0.91		0.50	1.66
$525	0.66		0.42	1.04
$525-600	0.76		0.49	1.16
> $600	1.00		1.00	1.00
CMS region				
Region I: Boston	7.69	*	2.88	20.57
Region II: New York	2.19	*	0.82	5.82
Region III: Philadelphia	1.00		1.00	1.00
Region IV: Atlanta	5.89	*	2.28	15.21
Region V: Chicago	4.43	*	1.73	11.37
Region VI: Dallas	6.92	*	2.68	17.86
Region IX: San Francisco	4.15	*	1.40	12.37
Regions VII, VIII, X: Kansas City, Denver, Seattle	4.80	*	1.72	13.41
Supplemental insurance				
Reports it is available	0.32	*	0.23	0.43
Reports it is not available	1.00		1.00	1.00
Medicare HMO				
Knows if Medicare HMO available	0.49	*	0.37	0.66
Does not know if Medicare HMO available	1.00		1.00	1.00
Understanding of plan withdrawal				
Understood what would happen	1.89	*	1.40	2.54
Did not understand what would happen	1.00		1.00	1.00

Table C.19 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Level of concern about what would happen			
Very concerned	0.99	0.71	1.38
Not very concerned	1.00	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	1.35	0.99	1.84
Satisfaction with time to choose			
Not at all satisfied	1.85	0.66	5.23
Not very satisfied	0.92	0.33	2.59
Somewhat satisfied	0.84	0.31	2.58
Very satisfied	0.80	0.29	2.20
Extremely satisfied	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.168.
Sample size for model = 3,146.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.20
Logistic regression of having coverage for prescription drugs after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	2.58	0.71	9.28
Age			
Under 65 years	1.05	0.80	1.37
65-74 years	1.00	1.00	1.00
75-84 years	1.05	0.85	1.30
85 years or more	0.83	0.58	1.20
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	1.62 *	1.09	2.40
Hispanic	0.83	0.47	1.46
Other	1.89 *	1.04	3.44
Gender			
Male	1.00	1.00	1.00
Female	0.96	0.80	1.16
Education			
Less than 9th grade	0.83	0.59	1.17
Some high school	0.99	0.76	1.28
High school graduate	1.00	1.00	1.00
Beyond high school	1.10	0.88	1.37
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	0.67	0.43	1.03
Good	0.66	0.44	1.01
Fair	0.69	0.45	1.07
Poor	0.41 *	0.23	0.71
Patient in hospital overnight or longer			
Yes	1.09	0.87	1.37
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	0.42 *	0.26	0.68
Beneficiary with someone else	0.50 *	0.32	0.81
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.07	0.79	1.45
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.13	0.93	1.38
No	1.00	1.00	1.00

Table C.20 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.91	1.39	2.63
No	0.63	0.45	0.89
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	0.96	0.75	1.23
Family or friend	1.53 *	1.01	2.29
TV, radio or newspaper	1.12	0.72	1.72
Other	1.86 *	1.26	2.73
Received letter from plan			
Yes	1.25	0.79	1.96
No, don't know, or no response	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	1.48	0.76	2.86
Moderate (15-34%)	0.83	0.49	1.43
Limited (6-14%)	1.10	0.65	1.85
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.97	0.53	1.79
$525	1.00	1.00	1.00
$525-600	1.24	0.94	1.62
> $600	1.23	0.90	1.68
CMS region			
Region I: Boston	0.34 *	0.21	0.53
Region II: New York	0.39 *	0.26	0.59
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	0.37 *	0.24	0.56
Region V: Chicago	0.47 *	0.31	0.71
Region VI: Dallas	0.51 *	0.34	0.78
Region IX: San Francisco	0.87	0.56	1.35
Regions VII, VIII, X: Kansas City, Denver, Seattle	0.79	0.50	1.27
Supplemental insurance			
Reports it is available	0.88	0.71	1.10
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.28 *	1.05	1.57
Does not know if Medicare HMO available	1.00	1.00	1.00
Understanding of plan withdrawal			
Understood what would happen	0.99	0.81	1.19
Did not understand what would happen	1.00	1.00	1.00

Table C.20 (continued)

Independent variable	Odds Ratio	95% Confidence Interval Lower limit	Upper limit
Level of concern about what would happen			
Very concerned	0.83	0.67	1.03
Not very concerned	1.00	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	0.73 *	0.58	0.92
Satisfaction with time to choose			
Not at all satisfied	0.83	0.43	1.59
Not very satisfied	0.81	0.43	1.54
Somewhat satisfied	0.86	0.47	1.58
Very satisfied	1.10	0.60	2.04
Extremely satisfied	1.00	1.00	1.00

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.146.
Sample size for model = 3,638.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.21
Sample strata by beneficiaries' reports of financial implications of plan withdrawal: 2001 and 2002

Beneficiary reports of financial implications	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Payments for monthly premiums						
Pay more now	55.1	62.7	42.0	46.9	55.4	55.5
Pay same amount now	12.2	9.8	9.9	12.0	11.7	12.9
Pay less now	11.7	7.4	17.3	9.2	11.3	7.7
Don't pay premiums[1]	10.8	8.9	16.0	15.3	10.9	13.3
Don't know or missing	10.3	11.3	14.8	16.6	10.8	10.6
Former plan paid cost of medicines						
Yes	66.3	41.7	71.3	43.9	62.6	74.3
No	22.6	45.5	20.0	46.5	26.2	15.9
Don't know or missing	11.1	12.8	8.7	9.7	11.2	9.8
Health insurance now pays cost of medicine						
Yes	49.9	35.1	51.3	24.0	47.4	52.6
No	37.0	52.3	38.3	64.7	39.8	37.9
Don't know or missing	13.1	12.6	10.4	11.3	12.9	9.5
Paying for prescription medicines						
Pay more now	43.9	35.6	49.6	41.3	43.0	---
Pay same amount now	24.8	37.2	21.0	34.4	26.6	---
Pay less now	12.5	9.2	13.1	6.9	11.9	---
Don't use prescription medicines	2.9	3.8	1.1	1.2	2.9	---
Don't know or missing	15.9	14.3	15.2	16.2	15.6	---

[1] Beneficiaries who paid no premiums both before and after plan withdrawal.

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

--- Numbers not available.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.22
Reports of financial implications of plan withdrawals by beneficiary characteristics: 2002

Beneficiary characteristic	Beneficiaries having to pay more for premiums	Beneficiaries having to pay more for prescription drugs
Unweighted base	n=3987	n=3987
	Percent	
All beneficiaries 2002	55.4	43.0
(2001)	(55.5)	(47.5)
Age Group		
Under 65 years	42.6	47.6
65-74 years	57.0	43.8
75-84 years	55.5	41.3
85 years or over	55.2	41.7
Gender		
Male	53.1	43.2
Female	57.1	42.8
Race/Ethnicity		
White non-Hispanic	57.6	43.2
All other racial groups and Hispanic	41.1	41.2
Education		
Less than 9th grade	48.2	45.0
Some high school	53.8	40.4
High school graduate	55.0	44.4
Beyond high school	61.4	44.4
Self-reported Health		
Poor or fair	52.4	47.7
Good, very good, or excellent	56.8	40.8
Hospitalized in past 12 months		
Yes	54.6	45.6
No or missing	55.6	42.2
Location		
Metropolitan	55.1	43.3
Non-metropolitan	63.2	32.6
New coverage arrangements		
Medicare HMO	44.4	42.6
Covered under Medicaid	31.3	27.1
Employer-provided	43.0	35.6
Supplemental	87.8	48.5
Original Medicare only	25.4	41.6

NOTE: Percentages are based on weighted data.

SOURCES: Survey of Involuntary Disenrollees 2002, 2001 CMS files

Indicates chi-square significant at .01 level

Table C.23
Logistic regression of having to pay more for premiums after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.62	0.13	2.91
Age			
Under 65 years	0.91	0.68	1.20
65-74 years	1.00	1.00	1.00
75-84 years	1.12	0.88	1.42
85 years or more	1.34	0.88	2.06
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.81	0.51	1.29
Hispanic	0.73	0.42	1.28
Other	1.33	0.66	2.69
Gender			
Male	1.00	1.00	1.00
Female	1.17	0.95	1.45
Education			
Less than 9th grade	0.84	0.59	1.21
Some high school	1.21	0.89	1.66
High school graduate	1.00	1.00	1.00
Beyond high school	1.36 *	1.06	1.75
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.01	0.62	1.64
Good	1.13	0.70	1.81
Fair	1.10	0.67	1.80
Poor	0.91	0.50	1.66
Patient in hospital overnight or longer			
Yes	0.75 *	0.57	0.97
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.41	0.83	2.40
Beneficiary with someone else	1.33	0.78	2.24
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.00	0.71	1.40
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.31 *	1.05	1.64
No	1.00	1.00	1.00

Table C.23 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.83 *	1.25	2.68
No	1.36	0.91	2.04
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	0.98	0.74	1.31
Family or friend	0.83	0.52	1.34
TV, radio or newspaper	1.07	0.67	1.71
Other	0.99	0.62	1.59
Received letter from plan			
Yes	1.09	0.65	1.84
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	0.54	0.24	1.23
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	1.52	0.66	3.51
Moderate (15-34%)	1.72	0.84	3.50
Limited (6-14%)	1.45	0.73	2.88
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.60	0.30	1.20
$525	1.00	1.00	1.00
$525-600	0.67 *	0.49	0.93
> $600	0.76	0.53	1.09
CMS region			
Region I: Boston	0.42 *	0.25	0.73
Region II: New York	0.19 *	0.12	0.30
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	0.19 *	0.12	0.31
Region V: Chicago	0.33 *	0.20	0.53
Region VI: Dallas	0.30 *	0.18	0.49
Region IX: San Francisco	0.49 *	0.30	0.82
Regions VII, VIII, X: Kansas City, Denver, Seattle	0.37 *	0.21	0.64
Supplemental insurance			
Reports it is available	1.35 *	1.06	1.72
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.30 *	1.02	1.65
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.23 (continued)

Independent variable	Odds ratio		95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal				
Understood what would happen	0.83		0.67	1.04
Did not understand what would happen	1.00		1.00	1.00
Level of concern about what would happen				
Very concerned	1.07		0.85	1.36
Not very concerned	1.00	##	1.00	1.00
Information about plan withdrawal				
Had enough information	1.00		1.00	1.00
Did not have enough information	1.10		0.86	1.41
Satisfaction with time to choose				
Not at all satisfied	1.07		0.52	2.23
Not very satisfied	1.02		0.50	2.10
Somewhat satisfied	0.93		0.47	1.86
Very satisfied	0.93		0.46	1.89
Extremely satisfied	1.00		1.00	1.00
New coverage arrangement				
Enrolled in Medicare HMO per CMS	1.00		1.00	1.00
Enrolled in Medicare PFFS per CMS	3.50	*	1.54	7.98
Report being enrolled in Medicaid	0.94		0.57	1.55
Report being covered through employer	1.12		0.78	1.60
Report having supplemental insurance	13.61	*	9.89	18.73
No other coverage identified - Medicare only	0.69	*	0.49	0.97

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.287. Sample size for model = 3,638.

SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.24
Logistic regression of having to pay more for prescription drugs after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.13	0.03	0.48
Age			
Under 65 years	1.19	0.89	1.58
65-74 years	1.00	1.00	1.00
75-84 years	1.01	0.80	1.27
85 years or more	1.07	0.72	1.58
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.65	0.41	1.03
Hispanic	1.67	0.93	3.00
Other	1.09	0.59	2.01
Gender			
Male	1.00	1.00	1.00
Female	0.90	0.73	1.09
Education			
Less than 9th grade	1.00	0.71	1.41
Some high school	0.86	0.65	1.15
High school graduate	1.00	1.00	1.00
Beyond high school	0.88	0.69	1.12
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.08	0.67	1.71
Good	1.23	0.79	1.93
Fair	1.31	0.82	2.09
Poor	1.86 *	1.01	3.42
Patient in hospital overnight or longer			
Yes	1.01	0.79	1.30
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.04	0.62	1.74
Beneficiary with someone else	1.05	0.63	1.74
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	0.94	0.68	1.29
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	0.94	0.76	1.16
No	1.00	1.00	1.00

Table C.24 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	3.49 *	2.46	4.96
No	0.47 *	0.32	0.71
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.26	0.96	1.66
Family or friend	0.82	0.53	1.26
TV, radio or newspaper	0.77	0.49	1.21
Other	1.12	0.69	1.81
Received letter from plan			
Yes	1.36	0.81	2.26
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	0.81	0.47	1.40
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.41 *	0.19	0.85
Moderate (15-34%)	0.51 *	0.27	0.95
Limited (6-14%)	0.36 *	0.20	0.66
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.39 *	0.23	0.66
$525	1.00	1.00	1.00
$525-600	1.31	0.98	1.75
> $600	1.42 *	1.03	1.97
CMS region			
Region I: Boston	2.36 *	1.40	3.96
Region II: New York	1.72 *	1.09	2.70
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	2.76 *	1.74	4.40
Region V: Chicago	2.07 *	1.28	3.34
Region VI: Dallas	3.81 *	2.37	6.11
Region IX: San Francisco	1.64 *	1.00	2.71
Regions VII, VIII, X: Kansas City, Denver, Seattle	2.33 *	1.37	3.97
Supplemental insurance			
Reports it is available	1.29 *	1.00	1.65
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.40 *	1.12	1.75
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.24 (continued)

Independent variable	Odds ratio		95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal				
Understood what would happen	0.95		0.78	1.17
Did not understand what would happen	1.00		1.00	1.00
Level of concern about what would happen				
Very concerned	1.16		0.91	1.47
Not very concerned	1.00	##	1.00	1.00
Information about plan withdrawal				
Had enough information	1.00		1.00	1.00
Did not have enough information	1.16		0.91	1.47
Satisfaction with time to choose				
Not at all satisfied	1.71		0.86	3.42
Not very satisfied	1.52		0.77	3.01
Somewhat satisfied	1.30		0.68	2.49
Very satisfied	0.90		0.46	1.74
Extremely satisfied	1.00		1.00	1.00
New coverage arrangement				
Enrolled in Medicare HMO per CMS	1.00		1.00	1.00
Enrolled in Medicare PFFS per CMS	2.26	*	1.20	4.26
Report being enrolled in Medicaid	0.57	*	0.34	0.95
Report being covered through employer	0.76		0.52	1.10
Report having supplemental insurance	1.55	*	1.18	2.04
No other coverage identified - Medicare only	1.01		0.71	1.44

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.212. Sample size for model = 3,638.
SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.25
Sample strata by beneficiaries' reports of impact on provider arrangements: 2001 and 2002

Beneficiary report of impact on provider arrangements	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Had to change personal doctor or nurse	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Yes	16.3	10.6	22.6	16.7	15.8	20.5
No	75.6	79.2	66.7	71.8	75.6	71.0
Don't know or missing	5.7	7.3	6.8	8.0	6.0	5.4
Do not have personal doctor or nurse	2.4	2.8	3.9	3.5	2.5	3.1
Problem to get personal doctor or nurse[1]	n=253	n=168	n=87	n=72	n=580	n=678
			Percent			
A big problem	18.2	14.1	29.2	18.1	18.6	19.2
A small problem	21.7	17.8	26.7	22.7	21.7	24.2
Not a problem	46.7	54.6	31.4	37.5	46.2	46.2
Don't know or missing	6.3	5.2	2.2	8.0	6.0	4.2
Have not found a new doctor yet	7.0	8.3	10.4	13.6	7.5	6.3
Seeing a specialist in former plan	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Yes	40.4	34.0	52.7	49.3	40.3	40.4
No	54.9	61.6	41.8	47.9	55.1	55.2
Don't know or missing	4.7	4.3	5.5	2.7	4.6	4.4
Had to stop seeing specialist[2]	n=631	n=550	n=207	n=217	n=1,605	n=1,636
			Percent			
Yes	13.0	9.7	24.9	22.6	13.6	22.4
No	75.1	79.5	65.5	66.2	74.8	66.8
Don't know or missing	9.1	8.6	8.2	10.3	9.0	8.6
Did not need to see a specialist	2.8	2.2	1.4	0.9	2.6	2.2

[1] Includes only beneficiaries who indicated "yes" to the question "When you changed from *nonrenewing plan* to the health insurance you have now, did you have to change your personal doctor or nurse?"

[2] Includes only beneficiaries who indicated "yes" to the question "During the last 6 months you were enrolled in *nonrenewing plan*, were you seeing a specialist on a regular basis?"

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.26
Impact on provider arrangements by beneficiary characteristics

Beneficiary characteristic	Beneficiaries that had to change their personal doctor or nurse[1]	Beneficiaries that had to stop seeing a specialist[2]
Unweighted base	n=3876	n=1570
	Percent	
All beneficiaries 2002	16.2	13.9
(2001)	(21.1)	(22.9)
Age Group		
Under 65 years	22.6	25.5
65-74 years	15.1	12.4
75-84 years	16.3	14.4
85 years or over	17.1	8.0
Gender		
Male	17.3	15.6
Female	15.4	12.5
Race/Ethnicity		
White non-Hispanic	15.1	12.3
All other racial groups and Hispanic	23.2	24.9
Education		
Less than 9th grade	17.1	18.0
Some high school	14.6	16.3
High school graduate	15.7	10.6
Beyond high school	17.5	15.1
Self-reported health		
Poor or fair	19.1	16.2
Good, very good, or excellent	14.6	12.5
Hospitalized in past 12 mths		
Yes	16.1	13.2
No	16.2	14.3
Location		
Metropolitan county	16.2	14.0
Non-metropolitan county	16.0	9.9
New coverage arrangements		
Medicare HMO	26.8	23.5
Covered under Medicaid	21.3	12.7
Employer-provided	12.7	4.8
Supplemental	6.9	4.7
Original Medicare only	14.1	25.2

[1] Excludes beneficiaries who indicated that "I do not have a personal doctor or nurse" in response to the question "When you changed from *nonrenewing plan* to the health insurance you have now, did you have to change your personal doctor or nurse?"

[2] Includes only beneficiaries who indicated "yes" to the question "During the last 6 months you were enrolled in *nonrenewing plan*, were you seeing a specialist on a regular basis?" (n=1605) and then excludes beneficiaries who indicated that "I did not need to see a specialist" in response to the question "Did you have to stop seeing your specialist?" (n=42).

NOTE: Percentages are based on weighted data.
SOURCES: Survey of Involuntary Disenrollees 2002, CMS files
Indicates chi-square significant at .01 level

Table C.27
Logistic regression of having to change providers after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.05	0.01	0.39
Age			
Under 65 years	0.98	0.70	1.39
65-74 years	1.00	1.00	1.00
75-84 years	1.07	0.79	1.45
85 years or more	0.85	0.49	1.47
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	1.02	0.60	1.75
Hispanic	1.07	0.57	2.01
Other	1.13	0.51	2.49
Gender			
Male	1.00	1.00	1.00
Female	0.81	0.62	1.06
Education			
Less than 9th grade	1.00	0.63	1.61
Some high school	0.80	0.55	1.16
High school graduate	1.00	1.00	1.00
Beyond high school	1.00	0.72	1.39
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	0.77	0.41	1.43
Good	0.96	0.53	1.72
Fair	1.21	0.66	2.21
Poor	1.47	0.68	3.19
Patient in hospital overnight or longer			
Yes	0.86	0.62	1.18
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.51	0.78	2.93
Beneficiary with someone else	1.08	0.56	2.08
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.29	0.85	1.98
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.01	0.77	1.32
No	1.00	1.00	1.00

Table C.27 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.25	0.76	2.03
No	0.91	0.53	1.58
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.06	0.75	1.50
Family or friend	1.49	0.89	2.49
TV, radio or newspaper	1.53	0.88	2.66
Other	1.35	0.74	2.45
Received letter from plan			
Yes	0.95	0.52	1.71
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	1.53	0.63	3.72
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.31 *	0.13	0.74
Moderate (15-34%)	0.21 *	0.11	0.42
Limited (6-14%)	0.43 *	0.23	0.80
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	1.53	0.60	3.87
$525	1.00	1.00	1.00
$525-600	1.05	0.72	1.53
> $600	1.90 *	1.25	2.89
CMS region			
Region I: Boston	3.43 *	1.20	9.82
Region II: New York	3.87 *	1.79	8.38
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	9.63 *	4.31	21.47
Region V: Chicago	4.75 *	2.13	10.62
Region VI: Dallas	9.40 *	4.14	21.36
Region IX: San Francisco	7.75 *	3.19	18.80
Regions VII, VIII, X: Kansas City, Denver, Seattle	6.34 *	2.51	16.02
Supplemental insurance			
Reports it is available	0.84	0.62	1.13
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.32	0.97	1.80
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.27 (continued)

Independent variable	Odds ratio		95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal				
Understood what would happen	0.77		0.58	1.01
Did not understand what would happen	1.00		1.00	1.00
Level of concern about what would happen				
Very concerned	1.02		0.76	1.36
Not very concerned	1.00	##	1.00	1.00
Information about plan withdrawal				
Had enough information	1.00		1.00	1.00
Did not have enough information	0.89		0.65	1.22
Satisfaction with time to choose				
Not at all satisfied	2.69		0.80	9.03
Not very satisfied	2.09		0.63	6.87
Somewhat satisfied	1.79		0.55	5.80
Very satisfied	1.98		0.60	6.46
Extremely satisfied	1.00		1.00	1.00
New coverage arrangement				
Enrolled in Medicare HMO per CMS	1.00		1.00	1.00
Enrolled in Medicare PFFS per CMS	0.39	*	0.18	0.84
Report being enrolled in Medicaid	0.38	*	0.21	0.71
Report being covered through employer	0.35	*	0.21	0.56
Report having supplemental insurance	0.16	*	0.11	0.24
No other coverage identified - Medicare only	0.24	*	0.15	0.39

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.139. Sample size for model = 3,539.
SOURCES: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.28
Logistic regression of having to stop seeing a specialist after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.00	0.00	0.02
Age			
Under 65 years	1.05	0.59	1.86
65-74 years	1.00	1.00	1.00
75-84 years	1.09	0.62	1.94
85 years or more	0.52	0.16	1.74
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	2.04	0.78	5.33
Hispanic	0.82	0.33	2.02
Other	1.34	0.38	4.74
Gender			
Male	1.00	1.00	1.00
Female	0.58 *	0.36	0.91
Education			
Less than 9th grade	1.76	0.85	3.62
Some high school	1.34	0.71	2.51
High school graduate	1.00	1.00	1.00
Beyond high school	1.40	0.77	2.57
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.07	0.13	8.90
Good	1.34	0.16	11.22
Fair	1.41	0.16	12.40
Poor	1.70	0.18	15.95
Patient in hospital overnight or longer			
Yes	0.69	0.42	1.13
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	8.54 *	1.95	37.44
Beneficiary with someone else	7.54 *	1.72	33.06
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.00	0.51	1.97
No or missing	1.00	1.00	1.00

Table C.28 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.51	0.53	4.32
No	0.83	0.26	2.69
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.41	0.75	2.64
Family or friend	1.82	0.84	3.93
TV, radio or newspaper	1.11	0.37	3.36
Other	1.82	0.61	5.42
Received letter from plan			
Yes	1.02	0.34	3.07
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	1.47	0.41	5.30
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	1.16	0.22	6.14
Moderate (15-34%)	0.35	0.09	1.44
Limited (6-14%)	0.79	0.20	3.23
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	1.03	0.29	3.62
$525	1.00	1.00	1.00
$525-600	0.91	0.49	1.70
> $600	2.63 *	1.27	5.45
CMS region			
Region I: Boston	2.44	0.47	12.65
Region II: New York	2.52	0.77	8.25
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	10.90 *	3.55	33.42
Region V: Chicago	1.93	0.56	6.59
Region VI: Dallas	10.30 *	3.25	32.63
Region IX: San Francisco	2.80	0.85	9.29
Regions VII, VIII, X: Kansas City, Denver, Seattle	6.98 *	1.88	25.98
Supplemental insurance			
Reports it is available	1.15	0.70	1.86
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.30	0.77	2.19
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.28 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal			
Understood what would happen	0.55	0.34	0.88
Did not understand what would happen	1.00	1.00	1.00
Level of concern about what would happen			
Very concerned	1.40	0.85	2.31
Not very concerned	1.00	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	1.89 *	1.13	3.19
Satisfaction with time to choose			
Not at all satisfied	10.97	0.84	143.97
Not very satisfied	13.52 *	1.05	174.50
Somewhat satisfied	14.09 *	1.12	178.09
Very satisfied	11.35	0.88	146.73
Extremely satisfied	1.00	1.00	1.00
New coverage arrangement			
Enrolled in Medicare HMO per CMS	1.00	1.00	1.00
Enrolled in Medicare PFFS per CMS	0.56	0.15	2.07
Report being enrolled in Medicaid	0.39	0.13	1.16
Report being covered through employer	0.16 *	0.06	0.46
Report having supplemental insurance	0.12 *	0.06	0.26
No other coverage identified - Medicare only	0.83	0.44	1.57

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.191. Sample size for model = 1,456.
SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.29
Sample strata by beneficiaries' reports of problems with access to care: 2001 and 2002

Beneficiary reports of problems with access to care	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Trouble getting health care they wanted or needed	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Yes	7.1	6.6	21.7	21.4	8.0	10.8
No	75.3	71.6	59.3	56.0	73.6	74.2
Don't know or missing	2.8	2.9	3.4	3.6	2.8	1.7
Did not try to get health care	14.8	18.9	15.6	19.1	15.5	13.3
Delayed seeking care because of cost	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Yes	16.4	19.5	36.4	44.2	18.3	21.9
No	68.8	63.7	53.0	44.5	66.8	67.1
Don't know or missing	2.8	3.1	3.8	2.3	2.9	1.6
Did not need medical care	12.0	13.7	6.8	9.0	11.9	9.4
Did not get prescribed medicines	n=1,556	n=1,609	n=385	n=437	n=3,987	n=3,780
			Percent			
Yes	11.7	10.5	31.1	33.0	12.8	15.0
No	75.7	74.7	57.9	59.6	74.4	74.7
Don't know or missing	5.1	5.8	5.2	3.3	5.2	4.0
Did not need prescribed medicine	7.4	9.1	5.8	4.2	7.6	6.3
Main reason did not get prescribed medicine[1]	n=179	n=166	n=120	n=141	n=606	n=566
			Percent			
Costs too much	75.6	84.4	81.7	84.2	77.8	71.3
Insurance won't cover/Plan limited amount of prescription medicine	7.8	3.0	5.8	.9	6.7	12.6
Didn't have way to get medicine	4.6	4.2	3.3	8.0	4.5	3.2
Didn't think medicine was necessary/Felt better and didn't need medicine	3.9	1.7	4.4	2.1	3.7	2.1
Don't like to take medicine	1.2	1.2	0.0	1.4	1.0	1.1
Unable to code/missing/don't know	6.9	5.5	4.8	3.4	6.3	9.8

[1] Includes only beneficiaries who indicated "yes" in response to the question "Since leaving *nonrenewing plan*, were any medicines prescribed for you that you did not get?"

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.30
Reports of problems with access to care by beneficiary characteristics: 2002

Beneficiary characteristic	Beneficiaries reporting have trouble getting care[1]	Beneficiaries reporting delaying care due to cost[2]	Beneficiaries reporting not getting prescribed medicines[3]
Unweighted base	n=3311	n=3514	n=3684
		Percent	
All beneficiaries 2002	9.5	20.8	13.9
(2001)	(12.4)	(24.2)	(15.0)
Age Group			
Under 65 years	26.3	40.8	33.6
65-74 years	7.7	20.2	14.8
75-84 years	9.0	19.9	11.3
85 years or over	9.0	12.7	5.2
Gender			
Male	9.6	19.4	12.0
Female	9.4	21.9	15.3
Race/Ethnicity			
White	8.3	20.0	12.8
All other racial groups and Hispanic	17.6	26.0	20.7
Education			
Less than 9th grade	15.1	25.7	15.6
Some high school	9.3	23.7	13.7
High school graduate	7.8	18.1	12.4
Beyond high school	9.4	20.8	16.4
Self-Reported Health			
Poor or fair	14.3	28.2	20.2
Good, very good, or excellent	7.0	17.0	10.6
Hospitalized in past 12 mths			
Yes	10.2	21.3	17.5
No or missing	9.3	20.6	12.8
Location			
Metropolitan county	9.5	20.6	14.0
Non-metropolitan county	8.1	26.7	10.4
New coverage arrangements			
Medicare HMO	9.2	17.0	13.5
Covered under Medicaid	11.5	28.0	13.4
Employer-provided	2.6	11.2	7.1
Supplemental	5.1	15.8	12.5
Original Medicare only	26.1	45.4	22.3

[1] Excludes beneficiaries who indicated that they did not try to get any health care since leaving *nonrenewing plan.*
[2] Excludes beneficiaries who indicated that they did not need any health care since leaving *nonrenewing plan.*
[3] Excludes beneficiaries who indicated that they did not need any prescription medicines since leaving *nonrenewing plan.*

NOTE: Percentages are based on weighted data.
SOURCES: Survey of Involuntary Disenrollees 2002, 2001, CMS files
Indicates chi-square significant at .01 level

Table C.31
Logistic regression of having trouble getting care after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.00	0.00	0.02
Age			
Under 65 years	1.91 *	1.23	2.97
65-74 years	1.00	1.00	1.00
75-84 years	1.11	0.71	1.72
85 years or more	1.36	0.68	2.70
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.89	0.48	1.67
Hispanic	2.03	0.97	4.26
Other	1.54	0.57	4.15
Gender			
Male	1.00	1.00	1.00
Female	1.01	0.71	1.45
Education			
Less than 9th grade	1.72	0.99	2.98
Some high school	1.28	0.79	2.08
High school graduate	1.00	1.00	1.00
Beyond high school	1.30	0.83	2.04
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.19	0.37	3.81
Good	1.71	0.56	5.21
Fair	1.87	0.60	5.81
Poor	2.82	0.81	9.81
Patient in hospital overnight or longer			
Yes	0.85	0.55	1.32
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	1.50	0.59	3.83
Beneficiary with someone else	1.23	0.50	3.04
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	0.85	0.50	1.42
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.33	0.92	1.92
No	1.00	1.00	1.00

Table C.31 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.27	0.69	2.35
No	0.77	0.38	1.54
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	0.91	0.55	1.51
Family or friend	1.40	0.73	2.70
TV, radio or newspaper	1.01	0.46	2.23
Other	1.86	0.93	3.71
Received letter from plan			
Yes	1.54	0.71	3.34
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	2.46	0.94	6.44
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.45	0.12	1.68
Moderate (15-34%)	0.45	0.14	1.42
Limited (6-14%)	0.69	0.21	2.22
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	2.07	0.88	4.91
$525	1.00	1.00	1.00
$525-600	1.70 *	1.05	2.75
> $600	1.99 *	1.15	3.43
CMS region			
Region I: Boston	1.88	0.60	5.85
Region II: New York	1.41	0.50	3.97
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	3.32 *	1.23	8.93
Region V: Chicago	1.39	0.51	3.79
Region VI: Dallas	3.20 *	1.16	8.85
Region IX: San Francisco	2.66	0.94	7.52
Regions VII, VIII, X: Kansas City, Denver, Seattle	2.95	0.89	9.83
Supplemental insurance			
Reports it is available	0.87	0.58	1.30
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.14	0.76	1.70
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.31 (continued)

Independent variable	Odds ratio		95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal				
Understood what would happen	0.97		0.67	1.41
Did not understand what would happen	1.00		1.00	1.00
Level of concern about what would happen				
Very concerned	1.39		0.95	2.03
Not very concerned	1.00	##	1.00	1.00
Information about plan withdrawal				
Had enough information	1.00		1.00	1.00
Did not have enough information	1.86	*	1.23	2.83
Satisfaction with time to choose				
Not at all satisfied	4.26		0.89	20.52
Not very satisfied	2.17		0.44	10.71
Somewhat satisfied	1.01		0.21	4.88
Very satisfied	0.48		0.09	2.54
Extremely satisfied	1.00		1.00	1.00
New coverage arrangement				
Enrolled in Medicare HMO per CMS	1.00		1.00	1.00
Enrolled in Medicare PFFS per CMS	1.69		0.64	4.47
Report being enrolled in Medicaid	0.99		0.45	2.19
Report being covered through employer	0.27	*	0.11	0.66
Report having supplemental insurance	0.71		0.41	1.24
No other coverage identified - Medicare only	2.91	*	1.72	4.93

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.152. Sample size for model = 3,025.
SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.32
Logistic regression of delaying care due to cost after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.01	0.00	0.05
Age			
Under 65 years	1.38 *	1.00	1.89
65-74 years	1.00	1.00	1.00
75-84 years	0.96	0.72	1.28
85 years or more	0.53 *	0.30	0.91
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.65	0.39	1.09
Hispanic	1.04	0.59	1.83
Other	0.95	0.41	2.19
Gender			
Male	1.00	1.00	1.00
Female	1.18	0.92	1.53
Education			
Less than 9th grade	1.62 *	1.06	2.48
Some high school	1.41	0.99	2.00
High school graduate	1.00	1.00	1.00
Beyond high school	1.34	0.98	1.84
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	1.85	0.82	4.15
Good	2.93 *	1.34	6.41
Fair	3.15 *	1.42	6.98
Poor	5.33 *	2.16	13.15
Patient in hospital overnight or longer			
Yes	0.88	0.64	1.21
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	2.04 *	1.08	3.84
Beneficiary with someone else	1.59	0.85	2.98
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	0.69	0.46	1.05
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	0.88	0.68	1.14
No	1.00	1.00	1.00

Table C.32 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	1.23	0.78	1.94
No	1.00	0.61	1.64
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.04	0.72	1.50
Family or friend	0.92	0.55	1.56
TV, radio or newspaper	1.06	0.61	1.81
Other	1.60	0.90	2.85
Received letter from plan			
Yes	1.16	0.62	2.16
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	1.29	0.68	2.46
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.97	0.42	2.27
Moderate (15-34%)	0.95	0.48	1.89
Limited (6-14%)	1.10	0.56	2.16
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.96	0.51	1.81
$525	1.00	1.00	1.00
$525-600	0.92	0.64	1.33
> $600	1.10	0.73	1.66
CMS region			
Region I: Boston	1.35	0.66	2.79
Region II: New York	1.67	0.91	3.05
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	2.04 *	1.08	3.84
Region V: Chicago	1.35	0.71	2.56
Region VI: Dallas	2.46 *	1.31	4.60
Region IX: San Francisco	1.47	0.77	2.81
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.52	0.73	3.17
Supplemental insurance			
Reports it is available	1.20	0.89	1.63
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.21	0.91	1.61
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.32 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal			
Understood what would happen	0.84	0.65	1.09
Did not understand what would happen	1.00	1.00	1.00
Level of concern about what would happen			
Very concerned	2.22 *	1.68	2.93
Not very concerned	1.00 ##	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	2.07 *	1.54	2.77
Satisfaction with time to choose			
Not at all satisfied	1.40	0.51	3.85
Not very satisfied	1.14	0.42	3.12
Somewhat satisfied	0.70	0.26	1.88
Very satisfied	0.41	0.15	1.12
Extremely satisfied	1.00	1.00	1.00
New coverage arrangement			
Enrolled in Medicare HMO per CMS	1.00	1.00	1.00
Enrolled in Medicare PFFS per CMS	2.80 *	1.34	5.84
Report being enrolled in Medicaid	1.76	0.97	3.20
Report being covered through employer	0.78	0.47	1.28
Report having supplemental insurance	0.97	0.66	1.43
No other coverage identified - Medicare only	3.49 *	2.32	5.25

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.187. Sample size for model = 3,200.
SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.33
Logistic regression of not getting prescribed medicines after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.00	0.00	0.02
Age			
Under 65 years	1.49 *	1.06	2.08
65-74 years	1.00	1.00	1.00
75-84 years	0.73	0.52	1.03
85 years or more	0.30 *	0.14	0.65
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.96	0.57	1.62
Hispanic	2.19 *	1.16	4.12
Other	1.04	0.50	2.17
Gender			
Male	1.00	1.00	1.00
Female	1.30	0.98	1.73
Education			
Less than 9th grade	1.10	0.70	1.73
Some high school	1.08	0.71	1.63
High school graduate	1.00	1.00	1.00
Beyond high school	1.42 *	1.00	2.01
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	3.29 *	1.06	10.18
Good	3.43 *	1.13	10.40
Fair	4.79 *	1.56	14.70
Poor	6.16 *	1.87	20.35
Patient in hospital overnight or longer			
Yes	1.18	0.86	1.63
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	0.93	0.42	2.06
Beneficiary with someone else	0.59	0.27	1.29
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.42	0.92	2.18
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.35 *	1.01	1.80
No	1.00	1.00	1.00

Table C.33 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	2.94 *	1.67	5.20
No	1.58	0.84	2.97
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.40	0.97	2.03
Family or friend	0.91	0.53	1.59
TV, radio or newspaper	1.52	0.84	2.75
Other	1.84 *	1.05	3.24
Received letter from plan			
Yes	1.03	0.54	1.99
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	1.07	0.47	2.44
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.71	0.23	2.17
Moderate (15-34%)	0.44	0.19	1.04
Limited (6-14%)	0.46	0.20	1.05
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	0.53	0.25	1.12
$525	1.00	1.00	1.00
$525-600	1.47 *	1.02	2.13
> $600	1.87 *	1.20	2.90
CMS region			
Region I: Boston	0.97	0.45	2.10
Region II: New York	0.78	0.39	1.59
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	2.93 *	1.53	5.61
Region V: Chicago	1.35	0.66	2.76
Region VI: Dallas	2.79 *	1.42	5.50
Region IX: San Francisco	1.17	0.54	2.51
Regions VII, VIII, X: Kansas City, Denver, Seattle	1.57	0.69	3.59
Supplemental insurance			
Reports it is available	1.01	0.73	1.40
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.24	0.91	1.70
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.33 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Understanding of plan withdrawal			
Understood what would happen	0.84	0.63	1.13
Did not understand what would happen	1.00	1.00	1.00
Level of concern about what would happen			
Very concerned	1.98 *	1.48	2.66
Not very concerned	1.00 ##	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	1.56 *	1.13	2.15
Satisfaction with time to choose			
Not at all satisfied	3.37 *	1.02	11.17
Not very satisfied	2.83	0.86	9.33
Somewhat satisfied	2.22	0.69	7.17
Very satisfied	1.38	0.41	4.59
Extremely satisfied	1.00	1.00	1.00
New coverage arrangement			
Enrolled in Medicare HMO per CMS	1.00	1.00	1.00
Enrolled in Medicare PFFS per CMS	1.98	0.92	4.28
Report being enrolled in Medicaid	0.98	0.48	1.99
Report being covered through employer	0.59	0.32	1.10
Report having supplemental insurance	1.18	0.82	1.70
No other coverage identified - Medicare only	1.74 *	1.14	2.65

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.146. Sample size for model = 3,358.
SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Table C.34
Beneficiaries' satisfaction with new coverage: 2001 and 2002

Beneficiary satisfaction	2002 Aged: Medicare HMO available	2002 Aged: No Medicare HMO available	2002 Disabled: Medicare HMO available	2002 Disabled: No Medicare HMO available	2002 Total	2001 Total
Unweighted base	n=1,556	n=1,609	n=385	n=437	n=3,987	
			Percent			
Satisfaction with health insurance now						
Less satisfied now	29.0	32.1	41.4	48.0	30.4	37.3
About the same now	40.5	35.1	31.2	22.5	39.0	37.7
More satisfied now	19.3	20.5	18.5	15.7	19.4	17.0
Don't know or missing	11.2	12.3	8.8	13.8	11.3	8.0

NOTES: Percentages are based on weighted data. Sections within columns may not sum to 100 due to rounding.

SOURCE: Survey of Involuntary Disenrollees 2002, 2001

Indicates chi-square significant at .01 level

Table C.35
Logistic regression of being less satisfied with health insurance after plan withdrawal

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Intercept	0.01	0.00	0.04
Age			
Under 65 years	1.07	0.82	1.40
65-74 years	1.00	1.00	1.00
75-84 years	0.90	0.71	1.12
85 years or more	0.59 *	0.40	0.89
Race/ethnicity			
White non-Hispanic	1.00	1.00	1.00
African-American	0.56 *	0.36	0.87
Hispanic	0.95	0.56	1.60
Other	0.81	0.43	1.54
Gender			
Male	1.00	1.00	1.00
Female	0.85	0.70	1.04
Education			
Less than 9th grade	1.07	0.76	1.51
Some high school	0.97	0.73	1.29
High school graduate	1.00	1.00	1.00
Beyond high school	1.10	0.87	1.40
Self-reported health			
Excellent	1.00	1.00	1.00
Very good	0.82	0.50	1.32
Good	1.22	0.77	1.94
Fair	1.61 *	1.00	2.59
Poor	2.07 *	1.16	3.72
Patient in hospital overnight or longer			
Yes	0.79	0.61	1.02
No or missing	1.00	1.00	1.00
Who makes health insurance decisions			
Beneficiary alone	0.98	0.60	1.61
Beneficiary with someone else	0.99	0.60	1.62
Someone else	1.00	1.00	1.00
Help completing survey			
Yes	1.00	0.73	1.36
No or missing	1.00	1.00	1.00
Seeing a specialist			
Yes	1.11	0.90	1.37
No	1.00	1.00	1.00

Table C.35 (continued)

Independent variable	Odds ratio	95% Confidence interval Lower limit	Upper limit
Former plan paid cost of medicines			
Yes	2.30 *	1.57	3.35
No	1.16	0.77	1.75
Don't know or missing	1.00	1.00	1.00
First source of information			
Plan	1.00	1.00	1.00
Doctor or other provider	1.11	0.85	1.45
Family or friend	1.01	0.66	1.53
TV, radio or newspaper	1.04	0.65	1.67
Other	1.23	0.79	1.90
Received letter from plan			
Yes	1.34	0.81	2.20
No, don't know, or no response	1.00	1.00	1.00
Location			
Metropolitan county	1.76 *	1.01	3.07
Non-metropolitan county	1.00	1.00	1.00
Medicare managed care market penetration (12/2001)			
High (35%)	0.79	0.40	1.57
Moderate (15-34%)	0.97	0.56	1.68
Limited (6-14%)	1.07	0.63	1.82
Minimal (< 6%)	1.00	1.00	1.00
Medicare payment rate to MCOs (2001)			
< $525	2.23 *	1.29	3.86
$525	1.00	1.00	1.00
$525-600	1.20	0.90	1.60
> $600	1.01	0.72	1.41
CMS region			
Region I: Boston	2.40 *	1.42	4.05
Region II: New York	1.43	0.89	2.31
Region III: Philadelphia	1.00	1.00	1.00
Region IV: Atlanta	2.33 *	1.46	3.72
Region V: Chicago	1.55	0.94	2.55
Region VI: Dallas	2.49 *	1.54	4.02
Region IX: San Francisco	2.19 *	1.30	3.68
Regions VII, VIII, X: Kansas City, Denver, Seattle	3.32 *	1.93	5.72
Supplemental insurance			
Reports it is available	1.11	0.86	1.42
Reports it is not available	1.00	1.00	1.00
Medicare HMO			
Knows if Medicare HMO available	1.41 *	1.12	1.76
Does not know if Medicare HMO available	1.00	1.00	1.00

Table C.35 (continued)

Independent variable	Odds ratio	95% Confidence interval	
		Lower limit	Upper limit
Understanding of plan withdrawal			
Understood what would happen	1.32 *	1.08	1.62
Did not understand what would happen	1.00	1.00	1.00
Level of concern about what would happen			
Very concerned	1.41 *	1.13	1.76
Not very concerned	1.00	1.00	1.00
Information about plan withdrawal			
Had enough information	1.00	1.00	1.00
Did not have enough information	1.32 *	1.04	1.67
Satisfaction with time to choose			
Not at all satisfied	3.19 *	1.58	6.43
Not very satisfied	2.95 *	1.48	5.88
Somewhat satisfied	1.93	0.99	3.76
Very satisfied	1.35	0.69	2.66
Extremely satisfied	1.00	1.00	1.00
New coverage arrangement			
Enrolled in Medicare HMO per CMS	1.00	1.00	1.00
Enrolled in Medicare PFFS per CMS	1.85	0.96	3.59
Report being enrolled in Medicaid	0.73	0.42	1.26
Report being covered through employer	0.84	0.58	1.21
Report having supplemental insurance	1.03	0.79	1.35
No other coverage identified - Medicare only	1.14	0.82	1.59

NOTES: Model is significant. Cox & Snell R-square for dependent variable = 0.116. Sample size for model = 3,638.
SOURCE: Survey of Involuntary Disenrollees 2002.
* Odds ratios are significant at 95% probability level.

Appendix D: Survey Instrument

OMB No. *0938-0817*

2002 Survey of Medicare Beneficiaries

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0817**. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Instructions for Completing This Survey

Please read this before you begin . . . .

1. For **each** question:

   < Be sure to read **all** the answer choices listed before marking your answer.

   < Mark the box to the left of your answer, like this:

   ☒ Yes
   ☐ No
   ☐ Don=t know

2. You will sometimes be instructed to skip some questions in this questionnaire. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

   ☐ Yes
   ☒ No ≡ **Go to Question 5**
   ☐ Don=t know

   If there is no arrow with a note telling you where to go next, then continue with the next question.

3. Please mark only one answer in each question except for Question 35.

Please go to the top of the next page and begin with Question 1.

YOUR FORMER HEALTH INSURANCE

1. Our records show that [MEDICARE HEALTH PLAN NAME] stopped covering you at the end of 2001. Is that right?

1 ☐ Yes ➔ **Go to Question 2**

2 ☐ No ➔ **Do NOT answer the rest of these questions. Please return this survey in the postage-paid envelope. Thank you.**

-1 ☐ Don't know ➔ **Do NOT answer the rest of these questions. Please return this survey in the postage-paid envelope. Thank you.**

2. If you needed <u>prescription medicines</u> when you were enrolled in [MEDICARE HEALTH PLAN NAME], would [MEDICARE HEALTH PLAN NAME] have paid any part of the cost of your medicines?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

CHOOSING NEW HEALTH INSURANCE

This next set of questions asks about your experiences with choosing new health insurance.

3. How did you <u>first</u> find out that [MEDICARE HEALTH PLAN NAME] was going to stop covering you? (Please mark only one answer.)

1 ☐ From [MEDICARE HEALTH PLAN NAME] itself

2 ☐ From the Medicare program

3 ☐ From a doctor or other health care provider

4 ☐ From a friend or relative

5 ☐ From a newspaper, radio, or TV

6 ☐ Some other way (Please specify)

_____

_____

4. Did you get a letter from [MEDICARE HEALTH PLAN NAME] telling you that it was going to stop covering you after December 31, 2001?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

For the following questions, please think about what happened <u>after you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME].</u>

5. Did you get enough information about your health insurance options after you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME]?

1 ☐ Yes

2 ☐ No

6. How satisfied are you with the amount of time you had to choose new health insurance?

1 ☐ Not at all satisfied

2 ☐ Not very satisfied

3 ☐ Somewhat satisfied

4 ☐ Very satisfied

5 ☐ Extremely satisfied

7. Who makes the decisions about which health insurance you get?

1 ☐ You alone make the decisions

2 ☐ You and a family member, friend, or insurance counselor make the decisions together

3 ☐ Someone else makes the decisions for you

8. Some people with Medicare have additional insurance to pay for health care and services that Medicare does not cover. This is called <u>supplemental or Medigap insurance</u>.

After you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME], was there a supplemental health insurance plan available in your area?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

9. Was there another Medicare HMO (also known as a managed care plan) available in your area?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

10. What did you think would happen if you did not change your health insurance before December 31, 2001?

1 ☐ I thought I would automatically be enrolled in another Medicare HMO

2 ☐ I thought I would be covered by the Original Medicare plan (also known as fee-for-service or traditional Medicare)

3 ☐ I thought I could still stay in the same insurance plan

4 ☐ I thought I would end up with no health insurance

5 ☐ Other (Please specify)

_____

_____

-1 ☐ Don't know

For the next set of questions, please think about what you were feeling <u>after you found out that you would no longer be covered by [MEDICARE HEALTH PLAN NAME].</u>

11. A personal doctor or nurse is the health provider who knows you best. This can be a doctor, a nurse practitioner, or a physician assistant.

How concerned were you that you might have to change your personal doctor or nurse?

1 ☐ Not at all concerned

2 ☐ A little concerned

3 ☐ Somewhat concerned

4 ☐ Very concerned

5 ☐ I do not have a personal doctor or nurse

12. How concerned were you that you would no longer be able to pay for your health care?

1 ☐ Not at all concerned

2 ☐ A little concerned

3 ☐ Somewhat concerned

4 ☐ Very concerned

13. How concerned were you that you would no longer be able to get the health care you need?

1 ☐ Not at all concerned

2 ☐ A little concerned

3 ☐ Somewhat concerned

4 ☐ Very concerned

YOUR CURRENT HEALTH INSURANCE

The questions in this section ask about the health insurance you have now.

14. Are you enrolled in a Medicare HMO or managed care plan now?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

15. Some people with Medicare are also covered by Medicaid, the state medical assistance program. Medicaid is run by your state to help some lower-income people pay for health care.

Are you covered by Medicaid now?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

16. Do you have supplemental health insurance now?

1 ☐ Yes ➔ **Go to Question 18**

2 ☐ No

3 ☐ I have not heard of this type of insurance ➔ **Go to Question 18**

17. What is the main reason you don't have supplemental health insurance? (Please mark only one answer.)

1 ☐ I don't need supplemental insurance

2 ☐ I couldn't find a policy with the benefits I need

3 ☐ I applied and was turned down

4 ☐ I thought I would be turned down because of my health

5 ☐ It costs too much

6 ☐ Some other reason (Please specify)

_____

_____

18. Do you get any of the health insurance you have now through your or your spouse's current or former employer or union?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

19. How satisfied are you with the health insurance you have now compared to [MEDICARE HEALTH PLAN NAME]?

1 ☐ Less satisfied now

2 ☐ About the same now

3 ☐ More satisfied now

20. If you need <u>prescription medicines</u>, will the health insurance you have now pay any part of the cost of the medicines?

1 ☐ Yes

2 ☐ No

-1 ☐ Don't know

21. Do you think you will pay more, less, or about the same now for <u>prescription medicines</u> as you did when you were enrolled in [MEDICARE HEALTH PLAN NAME]?

1 ☐ I will pay more now

2 ☐ I will pay about the same amount now

3 ☐ I will pay less now

-1 ☐ Don't know

4 ☐ I don't use prescription medicines

22. Sometimes people have to pay a monthly insurance premium for a Medicare HMO or supplemental insurance. This is separate from the amount you pay for Medicare Part B, which is usually deducted from your Social Security check each month.

Do you pay more, less, or about the same now for <u>monthly insurance premiums</u> as you did when you were enrolled in [MEDICARE HEALTH PLAN NAME]?

1 ☐ I pay more now

2 ☐ I pay about the same amount now

3 ☐ I pay less now

-1 ☐ Don't know

4 ☐ I didn't pay a premium for [MEDICARE HEALTH PLAN NAME] and I don't pay a premium now

GETTING THE CARE YOU NEED

The questions in this section ask about your experiences with <u>getting health care since you left [MEDICARE HEALTH PLAN NAME]</u>.

23. When you changed from [MEDICARE HEALTH PLAN NAME] to the health insurance you have now, did you have to change your personal doctor or nurse?

1 ☐ Yes

2 ☐ No ➔ **Go to Question 25**

3 ☐ I do not have a personal doctor or nurse

24. With the choices your current health insurance gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

1 ☐ A big problem

2 ☐ A small problem

3 ☐ Not a problem

4 ☐ I have not found a new doctor yet

25. Specialists are doctors like surgeons, heart doctors, psychiatrists, allergy doctors, skin doctors and others who specialize in one area of health care.

During <u>the last 6 months you were enrolled</u> in [MEDICARE HEALTH PLAN NAME], were you seeing a specialist on a regular basis?

1 ☐ Yes

2 ☐ No ➔ **Go to Question 27**

26. When you changed from [MEDICARE HEALTH PLAN NAME] to the health insurance you have now, did you have to stop seeing your specialist?

1 ☐ Yes

2 ☐ No

-3 ☐ I did not need to see a specialist

27. Since you left [MEDICARE HEALTH PLAN NAME], have you had any trouble getting health care that you wanted or needed?

1 ☐ Yes

2 ☐ No

3 ☐ I have not tried to get any health care since I left [MEDICARE HEALTH PLAN NAME]

28. Since you left [MEDICARE HEALTH PLAN NAME], have you delayed seeking medical care because you were worried about the cost?

1 ☐ Yes

2 ☐ No

3 ☐ I have not needed any medical care since I left [MEDICARE HEALTH PLAN NAME]

29. Since you left [MEDICARE HEALTH PLAN NAME], were any medicines prescribed for you that you did not get?

1 ☐ Yes

2 ☐ No ➞ **Go to Question 31**

3 ☐ have not needed any prescription medicines since I left that plan ➞ **Go to Question 31**

30. What was the <u>main</u> reason you did not get the medicine? (Please mark only one answer.)

1 ☐ I didn't think the medicine was necessary

2 ☐ I felt better and didn't need the medicine

3 ☐ I didn't have a way to get the medicine

4 ☐ I don't like to take medicine

5 ☐ It costs too much

6 ☐ Some other reason (Please specify)_____

_____

ABOUT YOU

This last set of questions is about you. These questions will help us learn about the people who answered the survey. This information will be kept confidential.

31. In general, how would you rate <u>your overall health</u> now?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

32. What is the highest grade or level of school that you have <u>completed</u>?

1 ☐ 8th grade or less

2 ☐ Some high school, but did not graduate

3 ☐ High school graduate or GED

4 ☐ Some college or 2-year degree

5 ☐ 4-year college graduate

6 ☐ More than 4-year college degree

33. During <u>the past 12 months</u>, were you a patient in a hospital overnight or longer?

1 ☐ Yes

2 ☐ No

34. Are you of Hispanic or Latino origin or descent?

1 ☐ Yes, Hispanic or Latino

2 ☐ No, not Hispanic or Latino

35. What is your race? Please mark one or more boxes.

1 ☐ White

2 ☐ Black or African-American

3 ☐ Asian

4 ☐ Native Hawaiian or other Pacific Islander

5 ☐ American Indian or Alaska Native

36. Did anyone help you complete this survey?

1 ☐ Yes

2 ☐ No

THANK YOU
Please mail your completed survey in the postage-paid envelope.